

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCÉDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
FRANCISCO UGARTE (SBN 241710)
francisco.ugarte@sfgov.org
GENNA ELLIS BEIER (SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (SBN 319071)
emilou.maclean@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: 415-553-9319
Fax: 415-553-9810

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. 3:20-CV-02731-VC

**PETITIONERS-PLAINTIFFS'
NOTICE OF MOTION AND MOTION
FOR PRELIMINARY INJUNCTION**

DATE: JUNE 2, 2020
TIME: 10:00 A.M.

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN
CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK (Mass. BBO# 688688)*
tcook@cooley.com
FRANCISCO M. UNGER (Mass. BBO#
698807)* funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs

*Admitted Pro Hac Vice

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NOTICE OF MOTION AND MOTION

PLEASE TAKE NOTICE that on June 2, 2020 at 10:00 a.m., Plaintiffs will and hereby do move, pursuant to Civil L. R. 7-1 and Fed. R. Civ. P. 65(a), for a preliminary injunction directing the Federal Defendants, *inter alia*: (1) to maintain the detainee populations at Mesa Verde ICE Processing Facility (“Mesa Verde”) and Yuba County Jail (“Yuba”) at levels that will permit necessary social distancing; (2) to produce, for review and approval by the Court, a Facility Plan to ensure each facility achieves consistent social distancing; (3) to temporarily abstain from adding new people to the facility; and (4) to take other, related steps necessary to protect detainees against the risk of infection during the COVID-19 pandemic. This motion is supported by the Memorandum of Points and Authorities below; the Federal Defendants’ interrogatory responses; contemporaneously filed declarations of expert and fact witnesses; all papers previously filed in this case; and such argument as the Court may deem necessary.

I. INTRODUCTION

In its order granting Plaintiffs’ Motion for Temporary Restraining Order (ECF 53, 4/29/20) (“TRO”), the Court found that there is a “‘tinderbox risk’ of the virus spreading in crowded detention facilities” and that “ICE has failed to take sufficient action to address the obvious health risks to detainees.” (TRO at 3-4; footnotes omitted.) The Court concluded that “the plaintiffs have demonstrated an exceedingly strong likelihood that they will prevail on their claim that current conditions at the facilities violate the class members’ due process rights by unreasonably exposing them to a significant risk of harm.” (*Id.* at 3; footnote omitted.) The Court further found that “it is undisputed that the agency has not come close to achieving social distancing for most detainees....” (*Id.* at 4.)

While some circumstances have changed since the TRO, Class members’ risk of infection remains unacceptably high. Despite a reduction in population at both facilities, Class members still lack the physical space needed to take the most basic steps to prevent the spread of COVID-19. ICE continues to add new Class members at both facilities.¹ Plaintiffs’ experts,

¹ ICE has also shuffled at least one Class member to another out-of-state facility. While Delfina Soto Soto’s bail application remained pending, Defendants released her *sua sponte* and five days

having reviewed the measures taken by Defendants to date, conclude that they are not nearly sufficient, and that conditions at both facilities remain dangerously unsafe.

This will not be the first time Defendants claim to have alleviated the constitutional violation at Mesa Verde and Yuba. Defendants recently made similar protestations in *Bahena Ortuño v. Jennings*, which Judge Chesney found unconvincing:

Although such new procedures alleviate some of the conditions identified in [prior orders], individuals presently detained at Yuba and Mesa Verde continue to lack the ability to engage in social distancing and, were the Court to direct petitioners to return to said facilities, petitioners would encounter that same impediment

Order Granting Preliminary Injunction, ECF 71 at 4, *Bahena Ortuño v. Jennings*, No. 3:20-cv-2064-MMC (N.D. Cal. May 7, 2020).

Plaintiffs continue to have an “exceedingly strong likelihood” of prevailing on the merits. Although Defendants appear to believe that the facilities’ populations have reached acceptable levels, the overwhelming facts show otherwise. Because population levels remain too high to allow for proper social distancing, Class members still sleep far too close together, stand in packed lines waiting to eat and to use bathroom facilities, and congregate in congested spaces for much of the day, creating perfect conditions for the rampant spread of COVID-19.

The preliminary injunction proposed by Plaintiffs (“Proposed PI”) appropriately addresses these problems. It is tailored to an ongoing public health crisis that is severe, but not permanent. It requires Defendants to present a detailed Facilities Plan to achieve necessary social distancing and other improvements at each facility; permits Plaintiffs to respond to the Plans; enables the Court to modify the Plans as necessary and approve them; and provides for ongoing reporting and oversight. It is necessary to (1) ensure the number of Class members remaining in the facilities is such that they are able to achieve social distancing in all of their daily activities, (2) prevent ICE from spreading the virus by adding new detainees without adequate testing or quarantine procedures or by transferring class members to other crowded ICE facilities, and (3) prevent any future recurrence of conditions violating Plaintiffs’ constitutional rights.

later rearrested her and flew her to a detention facility in Colorado where staff and a detainee had tested positive for COVID-19, all without notice to the Court and Plaintiffs. (*See* ECF 156, 168.)

II. FACTS

A. **Detainees at Mesa Verde and Yuba Continue to Live in Conditions that Make Adequate Social Distancing Impossible**

Defendants have provided limited information concerning the physical dimensions of living and bathroom quarters at both facilities, as well as limited information relating to meals and recreation.² Photographs taken inside Yuba and produced in connection with prior litigation, submitted here with the Second Supplemental Greifinger Declaration and the Andreas and Rodriguez Declarations, graphically demonstrate the overcrowded conditions still present there. These facts together with current Class member declarations compel the conclusion that, although some practices have changed and the populations of both facilities have declined, it remains impossible for Detainees to consistently achieve the necessary social distancing in any of their daily activities.

1. **Mesa Verde**

a. **Sleeping Quarters**

Mesa Verde has four dormitories (A, B, C, and D), each of which contains 50 bunk beds, which are separated by a median distance of just 3 feet 2 inches (edge to edge) (Int. Resp. 1.). The distance between top and bottom bunks is 4 feet 1 inch. (*Id.*) In some of the dorms, the population has been reduced to about 50, so that detainees are now sleeping one per bunk, alternating top and bottom bunks (Qazi ¶ 6; Trujillo-Lopez ¶¶ 4-5; Solis ¶ 5; Garcia ¶ 4.). Even this change, however, leaves a median distance of 5 feet 2 inches between the edges of bunks in which detainees are sleeping. (Qazi ¶ 6; Garcia ¶ 4; 2d Supp. Greifinger ¶ 22.) (As discussed below, because gravity pulls droplets down to the ground, staggering of bunks does little to alleviate the risk of transmission; only the shorter lateral distance of 3 feet 2 inches is relevant to that risk.) Whenever someone has to get down from a top bunk, they are “as close [to the

² Through late in the day yesterday, Defendants have been “supplementing” their interrogatory responses. Federal Defendants’ Responses, Supplemental Responses, Second Supplemental Responses, Third Supplemental Responses, and Fourth Supplemental Responses to Interrogatories are attached as Exhibits A-E to the Freeman Declaration and are referred to herein as “Int. Resp.”, “Supp. Int. Resp.”, “2d Supp. Int. Resp.”, etc.

occupant of the neighboring bunk] as if we were going to shake hands.” (Trujillo-Lopez ¶ 6; Solis ¶ 9; Qazi ¶ 6; Garcia ¶ 7.) Detainees keep belongings in storage bins located under bottom bunks, so a top bunk occupant who wants to retrieve belongings cannot avoid being right next to the occupant of the neighboring bottom bunk. (Solis ¶ 8.) In addition, Detainees assigned to top bunks often need to access the lower bunks, leaving occupants of adjacent lower bunks “nowhere ... to go.” (Trujillo-Lopez ¶ 9; Solis ¶ 12.)

b. Mealtimes

Class members now eat in shifts in Mesa Verde’s two dining rooms. (2d Supp. Int. Resp. 4-5.) However, they have to wait in line for 20-30 minutes before they can get their food, crowded “like elementary school kids lined up for lunch or people lined up for an amusement park ride—_inches apart from the person in front and behind us.” (Qazi ¶ 8; Garcia ¶ 9.) “[O]nce we get to the cafeteria we sit at separate tables, but to get there we are within arms-length of each other in line....” (Trujillo ¶ 7.)

c. Bathroom Facilities

Mesa Verde’s bathrooms have sinks located 2 feet apart from each other, and toilets and showers that are separated by 3 feet or less. (Int. Resp. 2.) Defendants have recently turned off water to every other sink, shower, and toilet in an apparent effort to increase the distance between people using them, but this has backfired by creating lines for the bathroom. “[N]ow that means people have to stand in line to wait for the bathroom, because there are fewer showers and sinks and there are so many of us.” (Trujillo-Lopez ¶ 10.) Shutting off some facilities “has made things worse, especially after yard time, when people have worked out and are sweaty and wait close together in line to shower.” (Garcia ¶ 14.) And even with alternate sinks shut off, the sinks are still not 6 feet apart. (Qazi ¶ 14.) This also has led to people washing their hands less, at a time when they should be washing their hands more. (Garcia ¶ 14.)

d. Recreation

Aside from brief periods in the exercise yard and dining room, Detainees spend 18-20 hours a day in the dorm. (Solis ¶ 16.) The only place to be during the day other than on one’s bunk is a small area in one corner that contains three small tables, one microwave, a sink, a hot

water dispenser, four phones and three computers. (Solis ¶ 14.) “With all of these items in one area, people often congregate there to use them even though the space is really small.” (Garcia ¶ 11.) When people use the computers “they are almost touching elbows.” (*Id.* ¶ 12; Qazi ¶ 11.) Watching TV requires people to crowd near each other’s bunks; “[if] I ask them to move their chair six feet away from me ... that puts them within six feet of someone else.” (Solis ¶ 13.)

2. Yuba

a. Sleeping Quarters

Unlike Mesa Verde, living quarters at Yuba consist of at least 24 differently configured spaces referred to as pods, tanks, cells and dorms. (Supp. Int. Resp. 1-3.) These range from B-Pod, which contains 25 bunks spaced two feet apart (side by side) and 3 feet apart (end to end); to G-tank, which contains 10 bunkbeds in rows only 3 feet 8 inches apart side by side and apparently only inches apart end to end; to S-Tank, which contains individual 2-person cells measuring 6 feet 5 inches by 8 feet 6 inches, with beds vertically separated by only 3 feet and a toilet and sink in each cell. (*Id.*; *see generally*, Rodriguez Exs. D-E and Andreas Ex. A.) In B-Pod, all the bottom bunks are full, detainees in bunks can reach out and touch each other, and the walkways are “so narrow that only one person can walk through at a time.” (Perez ¶ 5.) In pods and dorms with individual cells, the cells measure 6 feet by 11 feet 7 inches (Supp. Int. Resp. 1 & Appendix). Some of these cells are shared by two people (*id.*); but “[t]wo people cannot walk at the same time,” and “if your roommate did not brush their teeth, you can smell their breath.” (Singh ¶¶ 6-7; *see also*, Aguilar ¶¶ 5-6; Oxlaj ¶ 6.) Detainees stay in their cells at least 21 hours every day. (Birru ¶ 5.) This is similar for Detainees in tanks: “[T]here is always someone on the bed next to you on either side ... you can reach out and touch the [bed] next to you.” (Arias ¶ 5.) “We are all approximately 2 feet or an arms length apart from each other when we are sleeping in our bunkbeds.” (Mejia ¶ 5; *see also*, Mejia ¶¶ 4-5; Erazo ¶¶ 4-7; Aguilar ¶ 7.)

b. Mealtimes

Unlike at Mesa Verde, detainees at Yuba eat in their cells, dorms and pods. This creates social distancing problems both when detainees line up to receive food, and when they sit down to eat it. Remarkably, when lining detainees up to receive food, the facility has taken measures to

protect *servers*, but with total disregard for *detainees*. There is now a white tape line to indicate a distance of 6 feet between the first person in the receiving line and the server, but behind the line people have to line up within one foot or less of each other. (Pinheiro ¶ 10; Erazo ¶ 7; Singh ¶ 10; Perez ¶ 6; Arias ¶ 6; Aguilar ¶ 10.) Class member Pravindar Singh reports that this is “the only change I have seen in meal service” since arriving on March 19, 2020, and that, while standing in a long, U-shaped line to get food, “you could breathe on the neck of the guy in front of you.” (Singh ¶¶ 10, 3.) When eating food, detainees in dorms and “tanks” sit “shoulder to shoulder.” (Marroquin Dec. ¶ 6; Mejia Rosas ¶ 8; Aguilar Dec. ¶ 10; Pablo Dec. ¶¶ 6-7.) Detainees in cells have to sit at a tiny, 2-1/2 foot by 1 foot table next to the toilet. (*Id.* ¶ 11.) Detainees housed in dorms and tanks sit at long, narrow tables where their legs or elbows touch or at fixed tables in shared common areas in close proximity to other detainees. (Perez ¶ 7; Marroquin ¶ 6; Aguilar ¶ 9; Oxlaj ¶ 7; Birru ¶ 6; Erazo ¶ 6; Rodriguez Exs. A-C, F-G.)

a. Bathroom Facilities

Social distancing while using the bathrooms remains impossible. Detainees in cells use a single toilet and sink within one or two feet of the shared bunk. (Supp. Int. Resp. Appendix; Oxlaj ¶ 8; Singh ¶ 15.) Conditions for those in dorms, B-Pod and C-Pod (where approximately 40 of the ICE detainees are housed), are typical: toilets are 2 feet 8 inches apart and sinks are 11 inches apart. (Supp. Int. Resp. Appendix; Perez ¶ 9.) In the G through L tanks, where more than 23 of the ICE detainees are held, toilets are in the open right next to beds and the table, and upwards of nine people share one small shower. (Arias ¶ 7; Mejia ¶ 15; Aguilar ¶ 13.) Detainees in cells have to wait in lines of up to 20 people because the showers are only available during restricted hours of free time each day. (Singh ¶ 15.)

c. Recreation³

Detainees in cells such as E-Pod have access to a small “day room” where, due to overcrowding, it is simply not possible to be six feet apart from each other. (Singh ¶ 12.) There

³ Plaintiffs recognize that recreation is essential to Detainees’ physical and mental health and will involve transient interactions at a distance of less than six feet. The frequency and duration of those interactions can be greatly reduced, however, by appropriately adjusting to the overall detainee population.

are small tables in the room where six people may sit shoulder-to-shoulder. (*Id.*) The setup is similar in dorms such as B-Pod. (Perez ¶ 8.) “It’s impossible to stay six feet apart because the space is just too small and there are too many people [here].” (*Id.*) In tanks, “wherever you go, you are always near another person ... We feel like rats in a cage.” (Aguilar ¶¶ 11-12.) Detainees get one hour per day of recreation, on a rotating basis, in a crowded yard where social distancing is also impossible. (Arias ¶ 8.) To get to the yard, they have to walk down narrow corridors next to other housing units, “glued together” and just a few feet apart from those in tanks. (*Id.*; Aguilar ¶ 27.) “It’s like those people [walking by are] in the tank with us.” (Erazo ¶ 9.)

3. Additional Evidence that Conditions Have Changed Little at Either Facility

“Everyone is worried and scared. We don’t know what is going on. The place [Yuba] has remained the same.” (Singh ¶ 18.) In fact, it appears that after some initial improvements in sanitation following the filing of *Bahena Ortuño v. Jennings*, conditions at Yuba have regressed. “After the *Bahena Ortuño* lawsuit was filed, officers started giving us soap every day. But that stopped after a week or two, and now we are back to getting the little soaps two times a week and they just do not last.” (Erazo ¶ 16.) “When you finish the bar, you have to ask to get a new one; they do not automatically give you one. Sometimes they forget to do it, or they bring it days later.” (Arias ¶ 16.) New detainees are continuously arriving and are not being tested for COVID-19. (Qazi ¶¶ 17-19; Birru ¶ 9; Solis ¶ 19.)

Access to healthcare appears to be largely unchanged. Despite Defendants’ claims that there are no “actual or suspected cases” of COVID-19 at either facility, there is no basis for this conclusion due to the near-total lack of testing. “In Dorm A, there are always people coughing. My neighbor wakes up every day coughing ... Mostly, [the medical staff] give out ibuprofen and tell people to get medical attention when they get out of detention.” (Garcia ¶¶ 20-22.)

Ultimately, the situation for Class members remains dangerous and desperate. “Even with fewer people in here, it is still crowded. We are like sitting ducks in here ... Even though officials say they are trying to distance us it is not working. We are still often within inches of each other and they have not managed to actually create distance between us.” (Solis ¶ 21.) As

Class member Juan Jose Erazo Herrera explains, “ICE says we are a danger to society We are not a danger; we are in danger.” (Erazo ¶ 17.)

B. Expert Testimony Makes Clear that Class Members are Still Subject to Unreasonably Dangerous Conditions

In addition to a Second Supplemental declaration by Dr. Robert Greifinger and a Supplemental Declaration by Dr. Sandra Hernandez, Plaintiffs introduce declarations from Akiko Iwasaki, Ph.D. and Sarah Allen, M.D. Dr. Iwasaki is a professor of Immunobiology and Molecular, Cellular and Developmental Biology at Yale University, who explains in detail the relationship between the mechanisms of virus transmission and the need for social distancing. Dr. Allen is a professor of medicine in the Division of Infectious Diseases at the University of New Mexico, who discusses the range of pre-existing medical vulnerabilities that place Detainees at increased risk of severe clinical outcomes from COVID-19. Plaintiffs summarize below the highly detailed testimony of these experts to the extent that it is additive to testimony previously reviewed and accepted by the Court. (TRO at 5-7 and nn. 7-8 & 10-15.)

1. COVID-19 is Highly Contagious and Transmitted by Droplets and Aerosols

COVID-19 is highly contagious, in part, because of its low infectious dose, the long half-life of the virus, a long incubation and infection period, and transmission by asymptomatic carriers. (Iwasaki ¶ 19; Allen ¶ 9.) The infectious dose—the number of viral particles needed to cause an infection—is suspected to be low; as few as 1,000 particles can lead to infection, and a single cough or sneeze can contain as many as 200,000,000 particles. (Iwasaki ¶¶ 12-13.) These particles are contained in droplets with a diameter of a fraction of a human hair, or even smaller droplet nuclei. (*Id.* ¶¶ 9-10 & n.1.)⁴

2. Risk of Transmission and Viral Load Correlate to Exposure and Time

The likelihood of infection is correlated to exposure dose multiplied by exposure time. (Iwasaki ¶ 14.) Because of the minimal infectious dose, a brief exposure can result in infection,

⁴ Although the subject of scientific debate, evidence suggests that, separate and apart from droplets, the virus also can be “aerosolized” and then subject to airborne transmission, in which case it may remain in the air for hours and on surfaces for days. (Iwasaki ¶11; 2d Supp. Greifinger ¶¶ 6, 11; Allen ¶ 8 & n.1.)

but the longer a person is exposed to a carrier, the more likely they are to contract COVID-19. (*Id.*) Whereas *infection dose* (the amount needed to start an infection) is the “spark,” *viral load* (the amount of virus present in a volume of fluid) is the “flame”—how brightly the virus burns in an infected individual. (*Id.* ¶ 16.) The greater the viral load per exposure, the more severe the likely clinical outcome. (*Id.*) And once a person becomes infected, the person’s viral load increases as the virus takes over the cellular machinery and makes copies of itself at an exponential rate. (Allen ¶ 10.) The higher a person’s viral load, the more likely that person is to “shed” viral particles and infect others. (Iwasaki ¶ 15.)

3. A Broad Range of Pre-Existing Medical Conditions Increases Risk of a Severe Clinical Outcome from COVID-19 Infection

Defendants acknowledge that the risk of a severe clinical outcome is also increased by pre-existing comorbidities but claim that the CDC only identifies a handful of pre-existing conditions as increasing the risk. (Defs.’ Resp. to Common Issues Brief, ECF42, at 3.) The CDC itself, however, “lists a far broader range of medical conditions that can increase vulnerability to COVID-19.” (Allen ¶ 16.) Furthermore, “there are additional conditions beyond those recognized by the CDC that, according to recognized sources in the medical literature, are also associated with worse outcomes.” (*Id.*)

Dr. Allen describes in detail the conditions not acknowledged by Defendants, but recognized by the CDC and in the medical literature, including: HIV, obesity (BMI over 30), hypertension, cardiovascular disease, heart conditions, history of smoking, cancer, chronic respiratory or lung disease, Hepatitis C, autoimmune disorders, endocrine disorders, corticosteroid use, history of head injuries, prior organ transplant, blood disorders, neurological and neurodevelopmental conditions, high cholesterol, tuberculosis, and mental illness. (*Id.* ¶¶ 17-40.) There is a clear association between these conditions and severe or fatal outcomes. (*Id.* ¶ 48.) In addition, age increases risk along a continuum, with increased risk starting as young as 40 years of age; anyone older than 50 is “far from safe.” (*Id.* ¶ 37 & n.49.)

4. Social Distancing is Essential to Risk Reduction

Social distancing remains “the most critical tool to limit the individual and community risk of COVID infection.” (2d Supp. Greifinger ¶¶ 5, 14.) “Social distancing,” however, means

more than maintaining six feet of distance during brief encounters such as on the sidewalk or in a grocery store; it “first and foremost incorporates the idea of avoiding prolonged contact in confined spaces, i.e., congregate settings and mass gatherings, wherever possible.” (*Id.* ¶ 10.) Droplets propelled from a cough may carry the virus up to 16 feet and from a sneeze up to 27 feet. (2d Supp. Greifinger ¶ 11.) Multiple studies of indoor viral transmission confirm the risks posed to adjacent persons by people infected with COVID, including asymptomatic carriers. (Iwasaki ¶¶ 25-28.) “[W]hile not a perfect solution, six-foot social distancing is safer than no social distancing because it provides a significant degree of protection of individuals against droplet [as opposed to aerosol] transmission.” (*Id.* ¶ 22; *see also*, 2d Supp. Greifinger ¶ 11.) In the case of sleeping arrangements, however, a 10-foot separation is “the bare minimum to provide a degree of protection from infection for those sleeping in congregate settings” due to both the length of exposure while sleeping and the necessity of people getting in and out of beds. (2d Supp. Greifinger ¶¶ 14-15.)

5. “Staggered” Bunks Do Nothing to Mitigate the Risk of Sleeping in a Congregate Setting

Defendants assert that they are now “staggering” the placement of detainees in some bunk beds, apparently based on a notion that, because the diagonal distance between a top- and bottom-bed sleeper in adjacent bunks is slightly greater than the lateral distance between the bunks themselves, detainees must necessarily be safer. This is not supported by any expert opinion and is contrary to the basic science. Dr. Greifinger, who has over 30 years of experience in health care for prisoners, concludes that, because droplets fall due to gravity, staggering “does little to eliminate or reduce the risk of infection for those in neighboring bunks because droplets are heavy and fall from the air after traveling a few feet.” (*Id.* ¶¶ 16, 22.) Accordingly, “[t]he appropriate consideration of distance between beds is the lateral distance, regardless of whether individuals are on the top or bottom bunks, or whether they are staggered between upper and lower bunks.” (*Id.* ¶ 24.) Dr. Iwasaki agrees. (Iwasaki ¶ 32.)

6. Mesa Verde and Yuba Remain Extraordinarily Dangerous

Dr. Iwasaki, Dr. Greifinger and Dr. Allen have all reviewed Defendants’ interrogatory responses and conclude that “there is an extraordinarily high risk of infectious spread of COVID-

19” at Mesa Verde and Yuba (Iwasaki ¶¶ 7, 29); that it is “fundamentally unsafe to house individuals in the current conditions,” which “all but guarantee[] mass infection” (*Id.* ¶ 34); that the conditions at the two facilities “are ripe for outbreak” (Allen ¶¶ 6, 46); and that “ICE’s response to the threat of COVID-19 in Mesa Verde and Yuba has been woefully inadequate.” (2d Supp. Greifinger ¶¶ 3, 61.) Among other things, living in congregate settings leads to increased viral load exposure, which “affects how likely someone is to infect others, and how sick they become from that infection.” (Iwasaki ¶ 35 and ¶¶ 36-38.) Social distancing is “particularly important for those with pre-existing medical conditions.” (Allen ¶ 41.) Since the “many shared common spaces and amenities create a high likelihood of mass infection,” increased social distancing, along with other measures, is “vital to slowing the spread.” (Iwasaki ¶¶ 40-43.) Dr. Allen concludes that “the current conditions at Yuba County Jail and Mesa Verde are very dangerous” and “it is very likely people will become infected and die because of the unsafe conditions at these facilities.” (Allen ¶ 56.)

Dr. Greifinger in particular has reviewed each of the separate housing facilities at Mesa Verde and Yuba based on photographs, fact witness declarations, and interrogatory responses—including the “Defendants’ Fourth Supplemental Responses” served late yesterday—and concluded that “social distancing is impossible in the sleeping facilities used by detainees at Mesa Verde and Yuba given current structures and population levels.” (2d Supp. Greifinger ¶¶ 3, 18.) His detailed observations about the dangers posed by current conditions, together with photographs and schematic renderings, is found at ¶¶ 19-47 of his Second Supplemental Declaration. Of particular note, he observes that Defendants’ claim that a particular facility is at or less than “50% capacity” involves a “meaningless figure” that “does not tell me whether there is adequate social distancing.” (*Id.* ¶ 19.) What matters is whether “people are able to maintain distance from one another,” and that cannot presently be achieved at either Mesa Verde or Yuba. (*Id.* ¶¶ 20, 29.)

Dr. Greifinger concludes that “the only way to achieve meaningful social distancing in these facilities is to significantly decrease their population levels.” (2d Supp. Greifinger ¶ 61.) Dr. Iwasaki agrees that “the best way to reduce the risk of mass infection is to significantly

depopulate the facilities.” (Iwasaki ¶ 46.) In the absence of significant depopulation, “the second most important means of reducing risk of infection to individuals in these settings” is “ensuring a minimum of ten feet between beds for sleeping in a congregate setting and six feet for all other interactions (such as while standing in line, eating, or passing by other individuals).” (2d Supp. Greifinger ¶ 13.)

7. The Risks to Detainees—and to Public Health in the Surrounding Communities—Will *Increase* as Restrictions on the General Population are Lifted

As California undergoes a phased approach to modifying its existing stay-at-home order (Supp. Hernandez ¶¶ 8-11), the ability to practice social distancing will remain “fundamental” to all phases of the process. (*Id.* ¶ 12.) “As more members of the community rejoin the general public, the risk of community transmission into detention facilities is increased” because detention staff, vendors and visitors enter and exit the facilities each day. (*Id.* ¶¶ 14-14.) Thus, with public officials “bracing for a second wave of infection as more people circulate within their communities,” the “risk of infection for Mesa Verde or Yuba will, if anything, heighten.” (*Id.* ¶¶ 14, 21.) For these reasons, “[r]elaxing safety measures or increasing population levels within the facility [as restrictions on the general population are gradually lifted] could have dire consequences on detainees, staff and the surrounding health care infrastructure.” (*Id.* ¶ 24.)

III. ARGUMENT

The above evidence makes abundantly clear that the constitutional violation recognized by courts around the country remains to this day. In the context of the COVID-19 pandemic, civil detention at population levels that fail to accommodate social distancing violates the Fifth Amendment’s prohibition on punitive conditions of confinement in civil detention. Because social distancing remains impossible at Mesa Verde and Yuba, the constitutional violation this Court recognized three weeks ago when it granted Plaintiffs’ TRO is ongoing.

Although ICE has instituted some changes under pressure produced by litigation, its conduct has been characterized throughout by what the Court has referred to as a “lack of dexterity and flexibility,” and it has made clear since the inception of the pandemic that it will

not act on its own to protect detainees in its care. In the absence of a detailed and specific injunction, ICE will revert to “business as usual,” ignoring the risk to Class members.

A. The Court Has Broad Power to Fashion Relief that is Appropriate and Necessary to Alleviate the Identified Constitutional Violation

“Once invoked, the scope of a district court’s equitable powers . . . is broad, for breadth and flexibility are inherent in equitable remedies.” *Brown v. Plata*, 563 U.S. 493, 538 (2011) (quotations omitted). District courts may order “relief that the Constitution would not of its own force initially require if such relief is necessary to remedy a constitutional violation.” *Toussaint v. McCarthy*, 801 F.2d 1080, 1087 (9th Cir.1986); *see also Sharp v. Weston*, 233 F.3d 1166, 1173 (9th Cir. 2000) (noting district courts’ “broad powers to fashion a remedy” in affirming prison medical care injunction). The provisional remedies Plaintiffs propose are comfortably within the range endorsed by courts in this Circuit and around the country.

District courts in the Ninth Circuit have fashioned provisional remedies going to nearly every aspect of confinement, including hygiene and sanitation, medical care, basic jail infrastructure, and assorted aspects of daily life. *See Hernandez v. Cty. Of Monterey*, 110 F.Supp.3d 929, 959 (N.D. Cal. 2015) (ordering treatment protocols compliant with CDC guidelines); *Toussaint v. Rushen*, 553 F. Supp. 1365, 1385 (N.D. Cal. 1983), *aff’d in part sub nom. Toussaint v. Yockey*, 722 F.2d 1490 (9th Cir. 1984) (improvements to plumbing, heating, and cooling infrastructure, limits on double-celling, bedding and laundry standards, cleanliness in cells, mail rights, improvements to medical care, and limits on use of administrative segregation); *Sharp*, 233 F.3d at 1173 (requiring adoption and implementation of plan for training and hiring competent sex offender therapists and developing individual treatment plans). Courts have done the same where civil immigration detention conditions are unconstitutional. *See Unknown Parties v. Johnson*, No. 15-cv-00250-TUC-DCB, 2016 WL 8188563, at *15 (D. Ariz. Nov. 18, 2016), *clarified on denial of reconsideration*, 2017 WL 467238 (D. Ariz. Jan. 3, 2017), *aff’d sub nom. Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017) (addressing hygiene and sanitation deficiencies for immigration detainees and requiring clean bedding with blanket and mat, along with other relief, for all detainees held for more than twelve hours); *Orantes-Hernandez v. Smith*, 541 F. Supp. 351, 384-85 (C.D. Cal. 1982) (invalidating solitary

confinement of detained asylum seekers and requiring that they have access to legal information, legal visits and telephones).

District courts also frequently impose limits on population and on how many individuals can be housed in single cells to cure constitutional violations. *See, e.g., Pierce v. Cty. Of Orange*, 526 F.3d 1190, 1207 (9th Cir. 2008) (population caps are “an appropriate remedy when overcrowding rises to the level of constitutional violation”); *see also Webb v. Ada Cty.*, 145 F.3d 1343 (9th Cir. 1998) (alleviating “conditions of confinement problems [in overcrowded jail]... in full or in part by the population reduction.”); *McGrath v. Cty. Of Nevada*, 67 F.3d 248, 251 (9th Cir. 1995) (“strict population cap” to remedy overcrowding in Nevada jails); *French v. Owens*, 777 F.2d 1250 (7th Cir.1985) (affirming, among other remedies, imposition of population cap and prohibition of double-celling); *Balla v. Bd. Of Corr.*, 656 F. Supp. 1108, 1119 (D. Idaho 1987) (injunction imposing population cap and prohibiting double-celling). In fashioning population caps to remedy overcrowding, courts have issued, where needed, concomitant release orders to reduce inmate populations to constitutionally sound levels. *See, e.g., Duran v. Elrod*, 713 F.2d 292, 293 (7th Cir. 1983) (affirming order requiring release of certain pre-trial detainees, in tandem with population cap).

The Proposed PI, in similar but gentler fashion, would suspend the addition of detainees until Defendants achieve social distancing, and thereafter limit new arrivals to situations where the overall population is not increased and where those additional individuals are tested and/or quarantined upon arrival. *See Savino v. Souza*, No. 20-cv-10617-WGY, 2020 WL 2404923, *11 (D. Mass May 12, 2020) (granting preliminary injunction ordering “[n]o new immigration detainees may be admitted to Bristol County House of Correction.”). ICE would also be required to take reasonable steps to ensure that additions or transfers are consistent with the CDC’s guidance to “suspend” all transfers into facilities absent specified compelling circumstances.⁵ *See also Roman v. Wolf*, No. 20-55436, 2020 WL 2188048, at *1 (9th Cir. May 5, 2020)

⁵ CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html> (last visited May 21, 2020).

(declining to stay preliminary injunction provision requiring substantial compliance with these CDC guidelines).

As these cases show, it is well within this Court’s power to remedy constitutional violations at Mesa Verde and Yuba by imposing appropriate limits on the facilities’ populations after evaluating the Facilities Plans and any objections thereto; by limiting or conditioning transfers into and out of the facilities; and by ordering additional releases, as contemplated by the Proposed PI.

B. Requiring ICE to Maintain a Population Level that Enables Consistent Social Distancing is an Appropriate Remedy

As Plaintiffs explained in their motion for a TRO, holding civil immigration detainees in a congregate setting that presents a heightened risk for transmission of COVID-19 is excessive in relation to ICE’s interest in their detention, particularly given effective alternatives, such as conditions of release and electronic monitoring. (ECF 5 at 13-18.)⁶ Such detention also constitutes deliberate indifference. (*Id.* at 18-21.) The Court has already recognized—on a factual record little different than the one presented here, as to social distancing—that Plaintiffs are “exceedingly” likely to prevail on these due process claims. (TRO at 3.)

In many ways, the situation has only worsened since Plaintiffs briefed these constitutional issues and the Court granted provisional relief. Defendants continue to add new people to Mesa Verde and Yuba on a nearly daily basis, even as the Court grants release of certain Class members on bail. COVID-19 infections have continued to spread at ICE facilities around the country—1,181 ICE detainees are now confirmed to have the virus, while approximately 50 per cent of ICE administered COVID-19 tests come back positive.⁷ After

⁶ See also *Vazquez Barrera v. Wolf*, No. 4:20-CV-1241, 2020 WL 1904497, at *7 (S.D. Tex. Apr. 17, 2020) (“ICE has a number of alternative tools available to it to ensure enforcement, which it is free to use with Plaintiffs if they are released from detention. For example, ICE’s conditional supervision program uses a combination of electronic ankle monitors, biometric voice recognition software, unannounced home visits, employer verification, and in-person reporting requirements to supervise individuals released from detention.”); *Ferreira v. Decker*, No. 20 CIV. 3170 (AT), 2020 WL 1989417, at *11 n.6 (S.D.N.Y. Apr. 27, 2020) (collecting cases where courts imposed alternatives to detention in light of COVID-19).

⁷ See *Confirmed Cases*, <https://www.ice.gov/coronavirus>.

months of criticism, Defendants have failed to develop adequate testing and quarantine practices that reflect the reality of asymptomatic transfer. *See, e.g., Bent v. Barr*, No. 19-cv-06123, 2020 WL 1812850, at *6 (N.D. Cal. Apr. 9, 2020) (noting ICE’s failure to comply with CDC guidelines); *Bahena Ortuño v. Jennings*, No. 20-CV-02064-MMC, 2020 WL 1701724, at *4 (N.D. Cal. Apr. 8, 2020) (same). Moreover, despite population reductions at Mesa Verde and Yuba, social distancing remains impossible. *See Bahena Ortuño*, No. 3:20-cv-2064-MMC, ECF 71 at 4 (granting preliminary injunction where “individuals presently detained at Yuba and Mesa Verde continue to lack the ability to engage in social distancing”); *see also Pimentel-Estrada v. Barr*, No. C20-495 RSM-BAT, 2020 WL 2092430, at *11, 13-14 (W.D. Wash. Apr. 28, 2020) (granting TRO where “ICE has not reduced or rearranged the population at the NWIPC such that appropriate and meaningful social distancing is possible”). The constitutional violations underlying the TRO persist today.

The current pandemic has created an unprecedented problem that requires the kind of flexible response that is well within this Court’s “broad powers to fashion a remedy” under *Sharp, supra*, and similar cases. Plaintiffs’ claim is based on the (presumably) transient risk posed by a novel coronavirus that is highly contagious and for which there is no vaccine. (Complaint, ECF 1, ¶ 1.) Accordingly, the Court may order relief that is temporally limited by the duration of the pandemic’s unique threat to people in carceral settings and addresses the unacceptable elevated risks of contracting COVID-19 that they currently face. While Defendants have made some efforts to address conditions within the facilities, they are unable to prove that any of these efforts have appreciably reduced the danger to Class members. All of the scientific evidence is to the contrary.

Due to the exigency of the current situation and the limited amount of discovery to date, neither Plaintiffs nor the Court have complete visibility into the additional steps that may be available to Defendants to eliminate the constitutional violation. For this reason, it is appropriate to provide Defendants an opportunity to demonstrate how they could do so. But particularly in light of Defendants’ conduct to date, it is equally appropriate to demand that Defendants’ proposal be highly detailed and highly specific. Plaintiffs can then challenge the Facilities Plans

after inspecting the facilities and taking a Rule 30(b)(6) deposition. At that point the Court will be in a position to determine what further steps, if any, Defendants must take to ensure that Plaintiffs continued detention is constitutional, including guaranteeing appropriate “social distancing at the facilities.” (TRO at 5-6.)

The Proposed PI also provides for continuation of release applications under current protocols until the Facilities Plans are approved by the Court and implemented by Defendants; further release applications for medically vulnerable individuals thereafter as appropriate; and the suspension of adding detainees into the facilities until the Facilities Plans are approved by the Court and implemented. The Proposed PI also requires Defendants to provide necessary information to Plaintiffs’ counsel concerning transfers out (to prevent inappropriate efforts to remove persons from the Class) and transfers in (to identify new Class members); and contains provisions that permit the Court to modify it as conditions warrant, and ultimately to dissolve it when appropriate. Just like the approach taken by this Court in granting Plaintiffs’ TRO, Plaintiffs’ requested approach here is a “cautious and methodical” one that is appropriate to “address the constitutional problem presented by this case.” (TRO at 6.)⁸

C. These Facilities Will Remain Dangerous Long After Restrictions on the General Population Begin to be Lifted

Defendants have argued that, even if the Court requires corrective measures to be taken, the duration of such requirements should be pegged to the initial relaxation of “shelter in place” orders, and that anyone who is released from ICE detention should be automatically returned to detention as soon as government authorities begin to relax those orders. (Opp. to Motion for TRO, ECF 37, at 30.) For the reasons set forth by Dr. Hernandez, however, terminating injunctive relief so soon would be extraordinarily dangerous to both Class members and the communities surrounding the facilities. (Supp. Hernandez ¶¶ 16-27.)

⁸ Even if the Court were to determine that Defendants had succeeded in eliminating the constitutional violations it identified when granting Plaintiffs’ TRO, a preliminary injunction would remain necessary to prevent Defendants from undoing the measures they have taken thus far to address conditions at the facilities. Plaintiffs will address this issue in their response to Defendants’ anticipated motion to dissolve the TRO.

D. The Court Retains Inherent Power to Determine Individual Bail Applications During the Pendency of This Litigation

As this Court has already determined, “[i]n extraordinary cases like this, federal judges have the authority to release detainees on bail while their habeas cases are pending.” (TRO Order at 5; footnote and case cites omitted.) In addition, as Plaintiffs have previously briefed, the Court has independent jurisdiction over Plaintiffs’ claims for declaratory and injunctive relief under 28 U.S.C. § 1331. (Reply in Support of Motion for TRO, 39, at 4.) Plaintiffs are prepared to respond to any new argument from Defendants in their reply brief.

IV. CONCLUSION

This Court should grant Plaintiffs’ motion and issue a preliminary injunction in the form submitted herewith.

Dated: May 22, 2020

Respectfully submitted,

/s/ William S. Freeman
William S. Freeman
Sean Riordan
Angélica Salceda
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA

Bree Bernwanger
Hayden Rodarte
LAWYERS’ COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA

Judah Lakin
Amalia Wille
LAKIN & WILLE LLP

Jordan Wells
Stephanie Padilla
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN
CALIFORNIA

Manohar Raju
Public Defender
Matt Gonzalez
Chief Attorney
Francisco Ugarte
Genna Ellis Beier
Emilou H. MacLean
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO

Martin S. Schenker
Timothy W. Cook
Francisco M. Unger
COOLEY LLP

Attorneys for Petitioners-Plaintiffs

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF CAMILO ABEL
ARIAS MARROQUIN IN SUPPORT
OF PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF CAMILO ABEL ARIAS MARROQUIN

I, Camilo Abel Arias Marroquin, hereby declare and state:

1. My complete name is Camilo Abel Arias Marroquin. I am 27 years-old, and I am currently detained at the Yuba County Jail. The following declaration is based on my personal knowledge, and, if called to testify to these facts, I would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. I have been detained by ICE at Yuba County Jail since March 12, 2020, about two months. I was picked up by ICE on my release from San Quentin, and I was initially housed in J Tank. I came right around the time when everyone in California and the country started to get really scared about coronavirus.

Lack of Social Distancing While Sleeping

3. J Tank holds a maximum of 12 people with six bunkbeds. When I arrived, there were ten of us, and one empty bed. I was the only one from ICE, everyone else was from county. The beds were close to one another—just a few feet away. You could reach out and touch the other bed when you were lying down. I had someone above me and next to me the whole time.

4. On May 8, 2020, our whole pod was moved. They told us we needed to move because they wanted to put more people in J. We packed up our stuff and they brought all of us to L Tank.

5. L Tank is even worse than J Tank. It is a smaller, dirtier room. There were already three people in L Tank when we arrived, so now there are about ten of us. We sleep in two rows of beds. There are some free beds, but it does not matter because there is always someone on the bed next to you on either side. Like before, the rows of beds are close together, and you can reach out and touch the one next to you. The beds are attached to the wall, and it looks as though they have not been cleaned in years. They are quite narrow.

Lack of Social Distancing at Meals

6. We eat all of our meals in the same dorm where we sleep and use the restroom. We line up next to our bunks in line to get our food. We are less than six feet apart as we stand in

line. A deputy brings in a cart and gives each one of us a tray. The official is about 2-3 feet away when he is serving us food. Then we take all take our food to the table and eat at the same time. There is a long table where we sit shoulder-to-shoulder. It is nailed to the floor and the benches are welded to the table. The utensils are in bad condition. The glasses look old and cloudy. The spoons sometimes look like they have been chewed on, even on the handle.

Lack of Social Distancing While Using the Bathroom

7. The toilets and shower are also in our dorm room. There are three toilets and one shower for all of us. One toilet is next to one row of bunkbeds; the other toilet is next to the other line of bunkbeds; and the third is next to the shower and before the table. The toilets are completely in the open. There is no curtain, no wall, nothing. If you have to use the bathroom, you have no privacy. There is someone who has diarrhea in our dorm, so it has been pretty disgusting. The shower is separated from the rest of the dorm by a curtain only. The shower is the only place where you have even a little bit of privacy. Everywhere else, you can be seen by other dormmates, and by the camera that they have monitoring us at all times.

Lack of Social Distancing During Recreation

8. We have one hour a day of recreation time in the yard, five days a week. Otherwise, we stay in our dorm. One dorm goes to the yard immediately after the next, starting in the morning and going like that hour after hour each day. Our whole dorm goes to the yard at the same time. To get there, we walk down hallways that are maybe three feet or so wide. We are glued together as we walk down the hall to get there. The yard itself is not that large. Maybe about 12-14 feet wide and about 20 feet long, so we cannot stay six feet apart at all times.

9. The yard is also in bad condition. I do not know the last time they cleaned it. I do not think that they clean it between when one dormitory leaves and another comes in. There are two baskets to play basketball, some exercise bars, and a dirty bathroom. Even though the area does not get disinfected as far as I know, I need to deal with my stress by exercising. It feels like I am choosing between one part of my health and another. I touch the same bars, and basketball that everyone else has touched. They should be giving us gloves for this, but they have not.

10. The only other space I have been in is the phone room. ICE does not have staff there all the time, and I do not think the phone room is cleaned often. Inside there are two phones in a room that is not very large. If you were in there making a call at the same time as another person, you would definitely be less than six feet away. From what I remember when I was there last a few weeks ago, there is nothing to disinfect the phones with before you make a call.

Lack of Social Distancing During Trips to ICE Sacramento

11. When we are brought to the ICE Sacramento office, we cannot keep our distance from other detainees or the guards. Last week, when I went to ICE Sacramento to appear in immigration court, I was concerned to see that the security officer who brought us did not have a mask or gloves and did not maintain his distance from us. He puts handcuffs on us and a chain on our waist and a chain on our feet.

12. The officer drove us to ICE Sacramento in a van, where we are all sitting close together. In the van there are four seats which appear to hold two people each based on the number of seatbelts. But sometimes there are more than eight people in the van. Last week, there were ten detainees total in the van, all squished together, breathing the same air.

13. The officer then brought us inside the building where we wait in a group cell to appear by tele-video for immigration court. When we are in the cell waiting for court, we are not six feet apart. When we have our immigration court hearing, they bring us out to the “day room.” The security officer stands close to us while we have our hearing. The officer last week did not have gloves or a mask.

14. We spend maybe six hours at the ICE office in an enclosed space and then we return in the same van. If a security official gets the virus, I think we would all be infected by this exposure, and then we would bring it back with us to the facility.

Problems with Issuance and Use of Masks

15. We were given masks, but I do not like to wear them because I do not know how clean they are. Every week, we give our masks back to the staff. They clean all the masks and then give us a mask that someone else wore the week before. I do not know who wore it. I do not

know what they did to clean it, or who cleaned it. Even the clothes we were given (especially those of us from ICE) are dirty and torn, so I don't trust whatever cleaning process they have.

Lack of Proper Hygiene and Sanitation

16. We are given small bars of soap, like the kind you would get at a motel. It is about 3 inches and ½ inch thick. It is for our hands, for the shower, and for our clothes. When you finish the bar, you have to ask to get a new one; they do not automatically give you one. Sometimes they forget to do it, or they bring it days later. I prefer not to ask them, and I just buy soap in commissary. I am lucky because my family can put money on my books. Imagine if you did not have family who could do that for you.

17. Every day, a deputy comes in to clean with a bleach spray. We have to stay in there while they are spraying. The bleach is thrown on the ground, and sprayed on the tables, but they do not use a mop or anything. It is really strong smelling, and I have to cover my mouth. I do not think it is good for your lungs to smell bleach like that in an enclosed space with not much fresh air. I have always had asthma since I was little, and I do not think it is good for me. I do not feel confident that things are getting clean either. This is the only cleaning that happens, except sometimes when they let us have a mop for 30 minutes to clean the floors.

18. They take our temperatures but inconsistently. Sometimes, they come in every day for several days in a row to check us. We wait in a line by our bunks, just like we do when we are waiting for food. We are close together when we wait. Other times, they forget to come or just do not come.

Symptomatic Detainees and Lack of Access to Healthcare

19. There is a county detainee in my dorm who has been sick for about a week. He was arrested on the street and brought to Yuba about three weeks ago with a few other county guys who arrived. He has not really gotten out of bed in the past week. He has vomiting and diarrhea. He feels tired and his body hurts. He has asked to speak with a doctor, but to my knowledge no one has seen him. We are all just waiting for him to get a fever, or worse. We are worried that he has the virus, and that he brought it from outside.

20. I am afraid of contracting the virus because of my health conditions. As I mentioned, I have always had asthma. I also have mental health problems, including anxiety, depression, and stress. I take pills in the morning and in the evening here for my anxiety and to help me sleep. Years ago, I also had heart problems. All of a sudden, I would get pains in my chest. I managed this problem with medication in my country.

Conclusion

21. The response of the jail to the pandemic is a sad joke. They have put up flyers saying that we have to keep social distance, and warning us about the symptoms of coronavirus. But what does that do if there is no way to keep our distance, and no way to protect ourselves?

22. Yuba is worse than being in prison by far. I was at San Quentin, one of the oldest prisons in California. If I had the choice, I would go back to San Quentin a thousand times over Yuba. There, they clean the dorm areas three times a day (and this was before coronavirus). It is better maintained. They gave us new soap every day. The medical staff are more attentive; you have to get a medical exam every three months. When I came to Yuba, I could immediately see the difference. They gave me a dirty sweatshirt. When I tried to return it for a clean one, the deputy said to me, "Nobody gets special treatment here." As an ICE detainee, I feel that we are discriminated against by the deputies.

23. My hope is to reunite with my family, with my girlfriend. They have supported me through this, and I want to be with them. I would like to continue studying English. Before being arrested, I had started to take summer community college classes in Marin County. I was always a commercial painter. I have also worked in maintenance.

I, Camilo Abel Arias Marroquin, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 18, 2020

//s// Camilo Abel Arias Marroquin
Camilo Abel Arias Marroquin

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Genna Ellis Beier, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Camilo Abel Arias Marroquin in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 18, 2020 I read the foregoing to Camilo Abel Arias Marroquin and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from him because Yuba County Jail is located approximately three hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Genna Ellis Beier
Genna Ellis Beier

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF AROLDO
RODRIGUEZ DIAZ IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF AROLD RODRIGUEZ DIAZ

1. I was detained by ICE at Yuba County Jail from December 19, 2018 to May 15, 2020. During the time of my detention, I was detained in D-pod and H-tank. I was detained in D-pod for most of the time I was in Yuba, and I was in H-tank for the last week of my detention. I also am familiar with all of the tanks as well as the common space in A-pod because I walked by the tanks and A-pod daily when I went to use the phones.

2. I have reviewed the attached photographs, which I am informed were previously taken of the Tanks and A-pod at the Yuba County Jail.

3. Exhibit A is a photo of the common area, or “day room,” of one of the “tanks.” It resembles the day room of H-tank, but I know that some of the “tanks” are constructed the same.

4. Exhibits B & C is a photo of the common area of H-tank with the lavatory, sink, and shower visible.

5. Exhibit D is a photo of one of the sleeping areas of one of the “tanks.”

6. Exhibit E is a photo of the hallway by the “tanks.”

7. Exhibit F is a photo of the common space of A-pod.

8. I was informed that Dr. Pablo Stewart attested in a declaration filed in *Hedrick v. Grant* that the photographs in Exhibits A-F were taken of the common areas of the tanks, the sleeping area in the tanks, the hallway beside the Tanks, and the common space of A-pod. I can confirm that his descriptions of what the specific photographs are depicting remain the same.

9. Exhibit G is a photograph of the sleeping and common space in I-tank. I was informed that this was presented in a declaration of Carl Takei filed in *Lyon v. ICE* and described to be a photograph of the dormitory of I-tank. I can confirm that this is what the photograph depicts.

10. Although the photographs were taken before my detention at Yuba County Jail, they accurately show what the bunks, eating spaces and lavatory in H-tank look like, what the bunks in I-tank look like, what the hallway by the Tanks look like, and what the common space in A-pod looks like, as well as their layout, and their proximity to each other as of the time I

resided in Yuba County Jail. The paint colors are different in some places but the structures and layout are the same.

I, Aroldo Rodriguez Diaz, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Redwood City, California.

Date: May 20, 2020

//s// Aroldo Rodriguez Diaz
Aroldo Rodriguez Diaz

CERTIFICATE OF AFFIRMATION

I, Emilou MacLean, certify that I have read the foregoing to Aroldo Rodriguez Diaz and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Aroldo Rodriguez Diaz because the location where he is in quarantine is located approximately one hour away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 20, 2020

//s// Emilou MacLean
Emilou MacLean

Exhibit A



Exhibit B



Exhibit C



Exhibit D



Exhibit E



Exhibit F



Exhibit G



Privacy

Privacy

DSC00105

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

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DUNG TUAN DANG,

Petitioners-Plaintiffs,

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DAVID JENNINGS, Acting Director of the
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Enforcement; U.S. IMMIGRATION AND
CUSTOMS ENFORCEMENT; GEO GROUP,
INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF ASIF MASOOM
QAZI IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF ASIF MASOOM QAZI

I, Asif Masoom Qazi, declare the following based on my personal knowledge:

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Asif Masoom Qazi. I was born in Bangladesh and I am 31 years old. I have been in the United States since 1995 when I was only 6 years old.

3. I have been detained at Mesa Verde Detention Facility in Bakersfield, California since February 4, 2020, when I was detained by ICE after I voluntarily reported to an interview with immigration officials.

Lack of Social Distancing While Sleeping

4. At Mesa Verde, I am housed in Dorm C. There are approximately 50 bunk beds in the dorm. The west side of the dorm is lined with 25 bunk beds and the east side is lined with another 25 bunk beds. Each bunk bed is bolted down to the floor and approximately 3 feet apart from the next bunk bed. I am currently assigned to bunk number 41 and sleep on the top bunk.

5. On or around May 7, 2020, a Mesa Verde officer who supervises Dorm C started calling out bunk numbers and asked people assigned to those bunks to gather their belongings. The officer then notified those people that they would be moving down to Dorm A or B.¹ This was approximately 25 to 30 people. Most of these people wore orange uniforms which I understand signifies that they are designated by Mesa Verde as minimum-security. There were a few people wearing red uniforms—individuals designated as higher security—who were also moved to Dorm A or B, but these individuals were mostly elderly or medically vulnerable.

6. After people were moved out of Dorm C and into Dorm A or B, there remained approximately 50 people in my dorm. Even with the reduction, social distancing is still not possible. Mesa Verde officials recently assigned one person per bunk bed and require us that we sleep in a staggered manner with one person sleeping on a bottom bunk, and the person in the

¹ Dorms A and B are located on the first floor of Mesa Verde. Dorm B is closest to the medical unit. Dorms C and D are located on the second floor.

next bunk sleeping on the top bunk. However, when everyone lays down in their respective bunks, we are still not 6 feet apart. Some of us have recently measured the distance by having someone who is 6 feet tall place their head on the top bunk and their feet on the next bottom bunk and we have estimated that the beds are only around 4.5 feet apart. When I am in bed, for example, I sometimes have to get down to go to the bathroom or do anything else. Once I step down from my bunk bed, I am within 3 feet of the person in the next bottom bunk. With this many people, proper social distancing is impossible. We're in the dorm with all 50 people for at least 18 hours a day, and probably more.

7. On May 14, 2020 at around 3:00am, I heard some commotion in the dorm room and soon realized that officials were trying to assign a detainee to the bottom bed of bunkbed 36 even though there is already a person assigned to the top bed. The detainee already assigned to bunkbed 36 pushed back and said that he did not want anyone on the same bunkbed as him. Only then did officials retract. I believe that if the detainee already assigned to bunk 36 had not pushed back, the officials would have assigned two people to the same bunkbed.

Lack of Social Distancing at Meals

8. On or around May 7, Mesa Verde officials started allowing only 25 of us at a time to go to the dining hall to eat, but this does not include the dining hall workers (also known as porters). The dining hall is about 30-35 feet wide by 60-65 feet long. There are about 25 to 28 tables in the cafeteria, all bolted to the ground, so there is usually one person per table now. But engaging in social distancing is still not possible when we line up to go to the dining hall. When guards call "prep for chow," we line up in a single file—like elementary school kids lined up for lunch or people lined up for an amusement park ride—inches apart from the person in front and behind us. We wait in line, shoulder to shoulder, for about 20 to 30 minutes to leave our dorm room to go to the dining hall. The three porters (also detainees) who hand out the food are the first ones to go in the dining hall. The rest of us then enter the dining hall and are handed our food by the porters. Then we all take a seat at one of the tables. We have been instructed by officials to sit alone at each table, but it is not enforced. There is a yellow sticker placed on one seat per table and that is where we are supposed to sit. There have been times when more than 25

people are allowed to enter the dining hall at one time and, on these occasions, there are some tables that have more than one person at the table. We have to line up again inches from each other once it's time for us to go back to our dorm.

Lack of Social Distancing During Recreation Time

9. There is no limit on how many people in Dorm C can go out to recreation time. The recreation time blocks change but can be as early as 5:15am and as late as 8:30pm, for two-hour time blocks. It changes every day. During recreation time, people get on the few weightlifting machines, play soccer, basketball, handball or walk/run around the track. When people play soccer, basketball, or handball there is no way to engage in social distancing. People are touching the same ball, are blocking each other from masking a basket, or are running side-by-side. I usually use the weightlifting machines during recreation time and these machines are not cleaned in between uses. For example, there are two bench presses and, if I am using one, there is usually a line of people waiting to use the bench press. There is just one Mesa Verde officer monitoring recreation time and there are no instructions that we need to remain 6 feet apart from each other. Recreation time is not mandatory, and depending on the time of day, anywhere from about one-third to three-quarters of the people in Dorm C go out for recreation time.

Lack of Social Distancing During the Rest of the Day

10. During the majority part of the day, I am surrounded by people and it is difficult to remain 6 feet away. In Dorm C, there are 4 tables—2 on the south side of the dorm, 1 on the north side, and one in the middle of the dorm in the computer room. They are squared tables that are about 3-by-3 feet and people use them to play games and eat. The tables are bolted to the ground. People can bring their plastic chairs to sit at the table. There are often 4 to 5 guys at one table playing a card games, chess, checkers, or dominos, and officials often see them but do not tell them anything about remaining 6 feet apart. They are all around the small table, inches apart from each other.

11. There is also a small area with a row of 4 computers against the wall. If someone is sitting at each computer, there is no way to distance themselves. Each computer is about 1 foot

apart from the next computer. People use the computers to play games, but they also use them to draft up important documents for their immigration cases. I am not sure if or how often the computers are wiped down for cleaning. I have not seen anyone wipe down the computers.

12. Most people sleep around 6 to 8 hours a day. The lights are turned off at 11pm but, once count is over, we are free to move around if we want to. There are some people who lay in bed all day but, others like me, move around the dorm throughout the day. Count times are at 10:00am, 4:00pm, 11:00pm, 3:00am and 5:00am. The only time that we are required to stand up and be next to our bed is for the 4:00pm count. For the 10:00am and 11:00pm count, we have to be in or near our beds. Everyone is usually asleep for the 3:00am and 5:00am count.

Lack of Social Distancing While Using Bathrooms

13. We are also not able to engage in social distancing when we go to the bathroom. In Dorm C there are two bathrooms that are mirror images of each other, each approximately 8 feet by 45 to 50 feet. I recently tried to measure the walls of the bathroom and estimated these dimensions based on my experience as a union construction worker. In each bathroom there are 7 sinks, 5 toilets, and 5 shower stalls. All of the sinks, toilets, and shower stalls are lined against one of the long walls of the bathroom. Each sink faucet is about 1.5 feet apart from the next sink faucet; each toilet stall is about 3 feet wide; and each shower stall is about 3 feet wide, too.

14. As of recently, Mesa Verde officials have turned off the water on 4 of the 7 sinks. For example, the first sink works, sinks 2 and 3 are turned off, sink 4 works, sinks 5 and 6 are turned off, and sink 7 works. But even if I am standing at the first sink, there is still not 6 feet distance between me and the person at sink 4 since each sink faucet is about 1.5 feet apart. This is the case for both bathrooms in Dorm C so now, for 50 people, there are only 6 working sinks.

15. There is also no way to engage in social distancing when we use the toilets or showers. Each bathroom in Dorm C has 5 toilets—2 urinals and 3 regular toilets. The first two toilets are urinals and the first urinal is immediately next to sink 7. Mesa Verde officials have also turned off 2 out of the 5 toilets in each bathroom. This means there is a total of 6 toilets for 50 people in Dorm C (2 urinals and 4 regular toilets). The first urinal works but the second urinal is closed and won't flush. After that, every other regular toilet works. Each toilet stall is about 3

feet wide, with waist-height partitions separating each stall. The last toilet is immediately next to the first shower stall. There are 5 shower stalls in each bathroom, that are about 3 feet wide with shoulder-height partitions separating each one. The first shower works and is next to the last working toilet stall. If someone is in the last toilet stall and someone is showering in the first shower, they are about 3 feet apart. Mesa Verde officials have also turned off 2 of the 5 showers in each bathroom so now there are 6 total working showers for 50 people in Dorm C.

16. In Dorm C, we can use the bathroom and take a shower whenever we want. However, most people in my dorm tend to shower immediately after we return from recreation time. We have recreation time twice a day for 2-hour blocks—once in the morning and once in the afternoon. People often come back sweaty from recreation time and want to shower. All functioning showers are usually taken when people come back from recreation time and there are often people waiting to use the showers.

New Arrivals

17. This facility is still taking new people from outside. Since May 9, 2020, I know of at least two new people who were transferred from state prisons to Mesa Verde. Both individuals are in Dorm C. The first person arrived on or around May 9 and was transferred from Old Folsom State Prison. He told me that, after he was released from Old Folsom State Prison, ICE officials put him in a vehicle and drove him to the Stockton immigration facility. There, he said that ICE picked up more people and they were all then transported to the Fresno immigration facility. None of the people being transported wore masks and everyone was within inches of each other. Once they arrived at Mesa Verde, he was booked into the facility. He also told me that he was placed in a holding tank with 7 to 8 other guys. I have been in the holding tank before and I estimate that it is approximately 6 feet by 15 feet. In such a small space and with 8 to 7 other men, there is no way to engage in social distancing. Lastly, he told me that he was introduced into Dorm C the same day he arrived. He was never quarantined.

18. The second person arrived on or around May 13 from Corcoran State Prison. He told me that while he was in Corcoran, the prisoners were not properly quarantining. He told me that when he arrived at Mesa Verde, he was also placed in the holding tank while he was being

processed. He was still in his prison clothing. Like the first person, he told me that he was never quarantined and was immediately introduced into Dorm C.

19. Both individuals transferred into Mesa Verde told me that they were never tested before being introduced into the general population. All officials did was take their temperature and ask them if they had any symptoms. Then, they introduced them into Dorm C without taking any testing precautions.

Lack of Proper Hygiene and Sanitation

20. Detainees are the only ones who sweep and mop the common areas. They sweep and mop the main hallways where we all walk but they do not sweep or mop the spaces between our bunk beds. They also do not wipe down our bunk beds—that is left to each detainee, if they want to.

Conclusion

21. I am extremely concerned for those of us detained at Mesa Verde because, despite what I hear public health professionals say on the news, we cannot remain 6 feet away from another person, even if we try. I am always surrounded by people, even when I go to the bathroom. And even though gyms throughout the country are closed, people still use the weightlifting equipment during recreation time and stand in line to use it. There are also new people being introduced into the facility without the proper testing precautions taking place. I fear that the existing conditions inside Mesa Verde are ripe for an outbreak of COVID-19 infections and, once there is an outbreak, it will be too late.

I, Asif Masoom Qazi, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Bakersfield, California.

Date: May 18, 2020

//s// Asif Masoom Qazi
Asif Masoom Qazi

CERTIFICATE OF AFFIRMATION

I, Angelica Salceda, certify that on May 18, 2020 I read the foregoing to Asif Masoom Qazi and he affirmed that it is true and correct. I have not been able to obtain a signature from Asif Masoom Qazi because Mesa Verde Detention Facility is located approximately 2.5 hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Angelica Salceda
Angelica Salceda

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF AYLALIYA
ASSEFA BIRRU IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF AYLALIYA ASSEFA BIRRU

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Aylaliya Assefa Birru. I was born in Ethiopia and I am 36 years old. I have been a lawful permanent resident of the United States for over 6 years.

3. I have been detained at Yuba County Jail in Marysville, California since November 27, 2018.

Lack of Social Distancing While Sleeping

4. Before May 6, 2020 I was in Q4, where there were four people in total. Q4 has two bunk beds and two small tables, and that is it. One table was attached to the wall on the left, and one on the right. The seats were attached to the table. Q4 is small, so we were always close together. The only way to avoid it would be to sit in opposite corners. We would climb onto the top bunk by climbing up on the table, that is how close quarters it was.

5. On May 6, they moved me to Q1. There is nothing in Q1 except the bunk bed, a sink, a table attached to the wall, and a toilet with no walls or curtain around it. In Q1, there are two of us, a county inmate and me. It is a small room; I estimate about 9-by-12. I sleep in the top bunk. The distance between the top bunk and the bottom bunk is not more than three feet. We try to distance ourselves from one another by each staying on our own bunks most of the time, but it is still not six feet apart. We are in our cells for 21 hours every day. It is really difficult.

Lack of Social Distancing While Eating

6. In Q4 we all ate together at the small tables. The dining table in Q4 could fit four people. The dining table and chairs were both bolted to the ground. Usually the four of us would all eat at the same time. When I ate, my shoulders and elbows would touch the person I was sitting next to. Or, the women who slept on the bottom bunks would sit on the bottom bunk while they ate to have a little more space.

7. In Q1 Pod, the guards bring food to our room. There is a slot in the door that they pass the food through. There is only one green plastic chair in Q1, so I sit on the chair with the

tray on my lap to eat, or I sit on the toilet and put the food tray on the chair. The other woman sits on her bed.

Lack of Social Distancing While Using Bathrooms

8. There is only one very small shower. My bunkmate and I take turns. The shower is very unsanitary. I often skip taking a shower because I cannot bear to go in. There has been feces and blood in the shower. The detainees are responsible for cleaning up the shower space, but the guards do not provide us with adequate supplies for cleaning, just diluted cleaning solution that sometimes looks almost like water. Once I am done taking a shower, I get dressed inside the shower space because, if I go outside of that space, I am in a hallway that has cameras. That makes me very uncomfortable.

New Arrivals Constantly

9. It seems like they are making moves to accommodate new arrivals. When they brought us to Q1 they told us they were putting guys in Q4. We never know what is happening. They only thing they say is that they have to “make room.” I do know they are still bringing people in. It makes me question what is going on.

Lack of Proper Sanitation and Hygiene

10. My current bunkmate is a county detainee, and she works in the detention center’s commissary. She works four days a week. She does not wear her mask when she goes to work, and she does not wear gloves. When I was in Q4, I was next door to the commissary, and I could see her working and touching everything without gloves or a mask. I could see the guys working without masks, too. My bunkmate is often in contact with officers and guards while at the commissary, and with other detainees that she works alongside. She has been given no antibacterial soap or other cleaning supplies to disinfect herself after these interactions. I am worried that one of these officers or guards could be sick and infect my bunkmate. If my bunkmate gets sick, I could get sick too since we live and sleep so close to each other.

11. The phones and shower that I have access to are shared with new arrivals to Yuba who are in quarantine before being introduced into the general population. They are putting those people in S Tanks, 1-6. Those are cells with bunk beds, and when I have walked by there are

often two people in each cell. I am really nervous right now that we have to share phones with S Tank people. They could be infected and could get us sick. We do not have disinfectants, paper towels or anything. Everyone in the Q and S area share the phones and showers. It is just a hallway, and the door to rest of the jail is closed and locked. People from one cell get an hour, then they go back in, and people from another cell come out. There is no cleaning between cells. During that hour, that is the only time we have access to the showers and the phones.

12. The phone that I have access to is a shared phone. There is nothing to disinfect the phones or even paper towels. I do not believe that anyone else who shares the phone has cleaned it or has the supplies to clean it. These are the same phones that people in quarantine are using. I am worried that the shared phone is not clean and could make people sick. That scares me. They are supposed to be in quarantine to protect other people from getting infected, but I am sharing the phone and shower with them without any ability to clean the surfaces before I use them. But I do not have a choice. For the first week I was in Q1, the jug of hot water was shared by 8 people including myself and the S tanks. The tap on the jug of hot water was touched daily by all those people. They only started bringing each cell our own hot water on about May 14. There is no disinfectant available.

13. When it comes to disinfecting/sanitation, I can request a cleaning cart to clean my living space, but I am only allowed an hour to use it. This cleaning cart is used throughout Yuba and used by other people in other dorms. The last time anyone cleaned the common space was when the guards sprayed diluted bleach on the floor and on surfaces on May 6. Some guards do a better job of spraying multiple surfaces, like the table, floor, phone, and showers, while others only spray the floor. I sometimes ask to clean the common areas with the bleach spray so I can do a more thorough job of cleaning than the guards. The guards never clean the phones or the showers. That is up to us.

Problems with Issuance and Use of Masks

14. In late March, the guards handed out cloth masks to the detainees. At first, the guards specifically said, do not wash these masks. We will wash them. I was freaked out when they said that. The laundry room is very unsanitary. I try to wash my mask myself because I am

scared and do not trust what happens with the laundry at the detention center. The facility one time provided me with underwear that had stains on it. I only have basic soap to wash my mask. I am worried because I do not feel like my mask is clean. I do not think it can protect me from getting sick.

Conclusion

15. God forbid, if somebody has the virus, there is no question: we will all be infected with this virus. I feel we are here by God's grace.

I, Aylaliya Assefa Birru, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 19, 2020

//s// Aylaliya Assefa Birru
Aylaliya Assefa Birru

CERTIFICATE OF AFFIRMATION

I, Theodora Simon, certify that on May 19, 2020 I read the foregoing to Aylaliya Assefa Birru and that she affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Ms. Birru because Yuba Detention Center is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with her, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 19, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

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Enforcement; U.S. IMMIGRATION AND
CUSTOMS ENFORCEMENT; GEO GROUP,
INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF CARLOS
RENAN SOLIS MANZANILLA IN
SUPPORT OF PETITIONER-
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF CARLOS RENAN SOLIS MANZANILLA

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Carlos Renan Solis Manzanilla. I was born in Mexico and I am 59 years old. I arrived in the United States when I was 2 years-old and was granted Legal Permanent Status when I was a small child. I lived in the Los Angeles area since 1965.

3. I have been detained at Mesa Verde Detention Center in Bakersfield, CA since July 5, 2018.

Lack of Social Distancing While Sleeping

4. In Mesa Verde, I am in Dorm A which is located on the first floor of the facility. When I first got here, I was in Dorm C which is located on the second floor of the facility. I have noticed that Dorm C was much dirtier than Dorm A but, other than that, the dorms are set up in the same configuration.

5. Currently, there are about 50 people in Dorm A. There are 25 bunks on either side of the dorm, with two bathrooms in the middle. The beds are bolted down to the ground. There is supposed to be one person on a top bunk, and then in the next bunk, a person on the bottom bunk so we are staggered. Right now, I am on a bottom bunk and the top bunk next to me is currently empty.

6. I believe this configuration is so that Mesa Verde can house the most people in our small dorm. But even with the staggered sleeping arrangement, I do not believe we are safe because there are still too many people in the dorm.

7. Recently, there was another person in the top bunk next to mine. During the day, the person would sit in his chair between our bunks and he would be about a foot away from me when I was in my bunk. Sometimes I could wake up and he would be sitting right next to my head. I would often ask him to move to ensure there was space between us, but he did not always listen. It is common for people to sit in plastic chairs in between bunks. This means that they are a few feet from another person sleeping or sitting on the next bottom or top bunk.

8. Every person is assigned a big plastic container, like a storage bin, to store our stuff. We usually store those containers under our bunkbed. When people need to get stuff out of their containers, they have step into the space in between the bunkbeds and pull the container out. When they do this, they are often right next to the person in the bed next to them.

9. Regardless of the staggered sleeping arrangements, we have to get in and out of our beds for a number of reasons and end up being a few feet from the person in the next bunk bed. I do not see the point of sleeping in a staggered way if we still cannot practice social distancing.

Lack of Social Distancing at Meals

10. At Mesa Verde, we go to the dining hall three times a day. Officers come into our dorm and ask us to get ready and line up to go to the dining hall for “chow.” We line up towards the back door. We stand in line inches from each other, one after another, and it can take 10 to 20 minutes, even up to 30 minutes, before we actually go to the dining hall. This means that we are always inches away from the person in front of us and the person behind us when we line up to eat.

Lack of Social Distancing During the Rest of the Day

11. I keep to myself and try stay in my own area in my bunk as much as possible. I consider myself a loner. I do not mind people but, given the pandemic, I do not want to be around people. I have diabetes and hypertension and, based on news reports, I know this puts me at an elevated risk of dying from COVID-19.

12. Even though I keep to myself and stay in my own area, people often come within inches of me. For example, now that the bunk bed next to me is empty, people come sit there during the day to play cards or eat together. I’ve seen at least four people come hang out on that bunkbed at one time. They bring their chairs and use the bunkbed as a table or sit cross-legged on the bed. And when they sit there, they’re maybe two and a half feet away from me.

13. There are four TVs, one in each corner of the dorm: two in Spanish, two in English. My bunk is near the entrance to the bathroom, only the width of a plastic chair and I estimate maybe two feet away. My bunk is also near the TV so there’s lots of foot traffic. Since I

am so close to the TV, people will lean on my bed as they watch TV. People also bring their plastic chairs and sit within inches of my bed so that they can watch TV. Some people sit right in front of my bunk, and I ask them to move their chair six feet away from me. But that puts them within six feet of someone else. In order to watch the TV, you have to be close to a bunk. Otherwise, you are right in the way of people trying to get to the bathroom and the guards tell you to move. I try to use my walker as a barrier, but it does not really work.

14. The only other places to be during the day, other than your bunk, is the bathroom or the little area with the tablets, the phones, and a microwave. It is really small, maybe about 10-by-10. There are three square tables, and people sit there to play cards during the day, to use the tablets, or use the microwave to make food. The phones are right next to each other. There is also a phone booth with glass windows that people can use to make phone calls, but you are still only separated by a few feet and the booth is not totally enclosed. There are always people in this area, and they are always close to other people. It is impossible to be at a safe distance.

15. We have a standing count at 4pm every day. We stand by our bunk and the officers walk by and count us. While we stand and wait, we are maybe four or five feet apart at most from another person. The officers are only a couple feet away, and only some of them wear masks. I heard one officer say that wearing a mask fogs up his glasses, so he does not wear a mask. There are four other counts during the day. We have to be at our bunks, but we do not have to be standing next to our bunks for those.

16. Aside from the time I go to the dining hall and time in the yard, I am in the dorm for 18-20 hours a day.

Lack of Social Distancing While Using Bathrooms

17. There are two bathrooms in my dorm and I am about two feet from the entrance to the bathroom. Recently, Mesa Verde officials shut off the water to some of the showers, toilets and urinals. Now there is only one urinal per side of the Dorm, so 20 people are all using the same urinal.

18. If I notice that there is no one in the bathroom, I will sometimes go sit on a toilet just to get away from people. They call me the grouchy old guy because I tell all the young guys to stay away from me, but I am the grouch old guy that does not want to die.

New Arrivals

19. I know that there have been new detainee arrivals in my dorm because I see new faces all the time that I do not remember seeing before. Because I keep to myself, I do not know where they come from.

Conclusion

20. When I think about the pandemic and the conditions inside Mesa Verde, I think of it like food coloring and water—just one drop is all it takes to spread. One drop here, and we are done. The guards just do not care, and we are all afraid they are going to introduce the virus into the facility because they come and go from the facility.

21. Even with fewer people here, it is still crowded. We are like sitting ducks in here and cannot do much for ourselves. Even though officials say that they are trying to distance us, it is not working. We are still often within inches of each other and they have not managed to actually create distance between us.

I, Carlos Renan Solis Manzanilla, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Bakersfield, California.

Date: May 18, 2020

//s// Carlos Renan Solis Manzanilla
Carlos Renan Solis Manzanilla

CERTIFICATE OF AFFIRMATION

I, Theodora Simon, certify that on May 18, 2020 I read the foregoing to Carlos Renan Solis Manzanilla and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Carlos Renan Solis Manzanilla because the Mesa Verde Detention Center is located approximately five hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

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Petitioners-Plaintiffs,

v.

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INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF FERMIN
TRUJILLO LOPEZ IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF FERMIN TRUJILLO LOPEZ

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Fermin Trujillo-Lopez. I was born in Mexico and am 57 years old. I have been in the United States for approximately 40 years and for 30 years as a lawful permanent resident.

3. I have been at Mesa Verde Detention Center since September 16, 2019. At Mesa Verde, I am in D Dorm and have been here since I arrived.

Lack of Social Distancing While Sleeping

4. Right now, there are about 50 people in D Dorm. There are 25 bunks on both sides of the dorm, and the beds are bolted to the floor. There are two bathrooms in the middle.

5. I am assigned to a bottom bunk. Because of my age and my bad knee, I would not be able to get onto an upper bunk. On either side of me, there is someone on the top bunk, above me.

6. We are not able to be socially distanced while in our bunks or while sleeping. The problem is that the distance between the beds is less than three feet. They are simply too close together, and the bunks cannot be moved. It does not matter that the people in the bunk next to me are in the top bunk while I'm in the bottom bunk. When my neighbors get down from their bunks, they are very close to me, as close as if we were going to shake hands. They are not six feet away. They have to get down from their bunks to go to the bathroom and for meals.

Lack of Social Distancing at Meals

7. We cannot socially distance during mealtime. They can say they are doing something to encourage social distancing by having us all sit one person to a table to eat by ourselves, but that is the only time we are distanced. When the guards say it is time to eat, we get up and get in line. There are about 25 of us at a time waiting in line to walk to the cafeteria, and while we are in the line, we are very close to one another. It is totally ridiculous because once we

get to the cafeteria we sit at separate tables, but to get there we are within arms-length of each other in line and in the dorm.

Lack of Social Distancing During Recreation

8. We have the option to go out into the yard twice a day, for two-hour time blocks. The time changes every day. During yard time, almost everyone in Dorm D goes outside, and we walk down the narrow hall very close to one another to get to the yard. We are almost touching one another as we walk, we are so close. In the yard, some people play handball or basketball, or exercise, and everyone is close to everyone else. There is no social distancing. That does not exist.

Lack of Social Distancing During the Rest of the Day

9. One of my neighbors does not like to stay in the top bunk, where he sleeps, during the day. Instead, he sits on the bottom bunk for hours a day, right next to me. Other detainees will come over and talk to him or sit next to him on the bunk and play cards. They spend time during the day on the lower bunk and it is only a few feet away from me. I stay in my area and I try to stay away from other people but, when people come to talk with my neighbor, I cannot just run away. There is nowhere for me to go.

Lack of Social Distancing While Using Bathrooms

10. They shut off the water in some of the showers, toilets, and urinals in the bathroom to try to lessen the people in the bathroom and help with social distancing. But now that means people have to stand in line to wait for the bathroom, because there are fewer showers and sinks and because there are so many of us. There is only one urinal and two toilets for 25 people. Especially in the morning when we all wake up and need to use the bathroom to urinate and brush our teeth. For the bathroom, it is like we are standing in line at a movie theater, one person right after the next.

Conclusion

11. I'm diabetic and have high cholesterol and high blood pressure. We know that there is an active outbreak at Otay Mesa Detention Center and that people there have died of the coronavirus. I have been told that people at Otay Mesa are in individual cells, and even that has

not prevented the spread of the virus. It is because as soon as they leave their cells, for anything, they have contact with other detainees and guards. So, they are not protected. And if they are at risk, even though they are isolated for most of the day, I think we are at even greater risk.

12. Social distancing is not possible in Dorm D. We go to the bathroom, and we are close to each other. We gather at mealtime in a line right next to each other. We are in the yard together, and to get there we walk very closely together down the hall. Literally, we are together and near each other all day every day.

13. Mesa Verde is not resolving the problems. There are just too many people here. They need to leave an empty bunk in-between people, and only that might allow us to be distanced. If they reduced the population in my dorm from 50 to 25 people, maybe we could be socially distanced while we sleep and there would be fewer people trying to share the bathrooms and the phones. But I do not know how we would avoid lines at mealtime and for the bathrooms.

I, Fermin Trujillo-Lopez, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Bakersfield, California.

Date: May 18, 2020

//s// Fermin Trujillo-Lopez
Fermin Trujillo-Lopez

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Theodora Simon, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Fermin Trujillo-Lopez in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 18, 2020 I read the foregoing to Fermin Trujillo-Lopez and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Fermin Trujillo-Lopez because the Mesa Verde Detention Center is located approximately five hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF GILBERTO
PABLO PEREZ IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF GILBERTO PABLO PEREZ

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in Zepeda Rivas, et al. v. Jennings, et al., 20-cv-02731-VC.

2. My full name is Gilberto Pablo Perez. I was born in Todos Santos Cuchumatán, Guatemala and I am 32 years old. I have been in the United States since 2016. My wife and two children are currently living in the United States. They have all been granted asylum.

3. I was detained at Yuba County Jail in Marysville, CA starting on February 11, 2020. I was ordered released on May 16, 2020. At Yuba County Jail, I was last housed in B Pod. In B Pod, there were 25 bunk beds, with capacity for 50 people. The bunk beds were all on the first floor. When I was ordered released, there were 21 people in B Pod. From late April until I was released, five new people arrived in B Pod. These new people said they had arrived from prison. I do not know if they were quarantined before arriving.

4. On May 8, 2020, two detainees were transferred into B Pod. I know this because I saw the two detainees at another pod in the jail when I was escorted to make a legal call that same day.

Lack of Social Distancing While Sleeping

5. There was no way to stay six feet apart in B Pod. There were too many people there. All of the top bunks were empty, but the bottom ones were almost full. There were people sleeping on both sides of me. I was surrounded by beds to my left, right, at my feet and head. If I stretched my arm out to the left, I could touch the person who slept there. There were 3 lines of beds, one in the middle, one against the wall and the other on the opposite side of the wall. The walkways between the beds were so narrow that only one person could walk through at a time. There were no doors or windows on the wall furthest from the entrance. If you slept on that side of the pod, there was another bed at your feet, with the middle row of beds on your right side just two feet away. The line of beds in the middle was only one foot away from the row of beds closest to the entrance. You could not avoid other people because we all had to walk through the same perimeters to get by.

Lack of Social Distancing at Meals

6. We were all served our meals at the same time. There was white tape on the ground where the line started, and we formed a single file line. The person serving stood about five or six feet away from us. I could easily touch the person in front of me in line if I wanted to, and the person behind me could touch me. That is just how we lined up, and no one ever told us to do something differently. We were served our food on the first floor at the dorm entrance.

7. The tables and benches on the second floor were welded to the ground, so we could not move them. There were nine tables, so we usually sat three to four people per table. Some of the tables were round and others square. We could not move the tables or chairs, so we had to sit close together. Sometimes, we sat right next to each other, and our elbows bumped as we ate.

Lack of Social Distancing During the Rest of the Day

8. During the day, almost everyone in our pod would spend time on the second floor hanging out at the tables. The television was on the second floor, so we spent a lot of time huddled together watching television. The majority of detainees did not wear masks. There was not much else to do, so we spent a lot of time together there. It was impossible to stay six feet apart because the space was just too small and there were too many people in B Pod. I would sometimes spend time at my bunk in order to keep distance from others.

Lack of Social Distancing While Using the Bathrooms

9. There were four toilets on the top floor and two on the bottom floor. The toilets were very close to each other. There is a small wall that is 3 feet high and 2 feet wide separating each toilet. The toilets are two or three feet away from each other. When sitting on the toilet, you could see the person next to you. There were two showers on the top floor and one on the bottom. The two showers were separated by a wall that completely covered the person next to you.

Continuing Lack of Proper Sanitation and Hygiene

10. We were given a small piece of soap to shower. The bar of soap only lasted for a few showers. The sinks did not have soap to wash your hands. There was a yellow disinfectant

next to the sinks, but I tried to avoid using it because it is the same disinfectant we used to clean. One of my podmates, who speaks English, read the label on the bottle and told me that it says the liquid can cause damage to your skin and eyes.

Problems with Issuance and Use of Masks

11. A cloth mask was given to each person in my Pod. The masks were washed once a week, but I was fearful that I would be contaminated if someone who previously wore the mask was sick. When we were given the masks, we were not told it was mandatory to wear them. On May 8, 2020, I was taken to the private phone booths to make a legal call. The guard who escorted me was wearing a mask. As I was walking by the other pods, I noticed that some detainees were wearing masks, but most of them were not.

12. The only changes I saw after the COVID outbreak were the cloth masks and daily temperature checks.

Problems with Air Circulation

13. There was a window at the dorm entrance where we could see into other dorms. The air vent in B Pod was located on the ceiling. The air flowed down, and the system was on all day. The vents were dusty because they were not cleaned, and the air was on you could see the dust falling to the ground.

14. We all felt desperate at Yuba because the virus can be transmitted in the air. We worried a lot about that. If one person was infected it is likely that we would all catch it. I was so afraid to die in there.

Photograph Attached as Exhibit A

15. I have reviewed the photograph, attached hereto as Exhibit A, which I am informed was previously taken of C Pod at the Yuba County Jail. I understand that ICE has provided answers to interrogatories that say that the dimensions of B Pod and C Pod are the same, that each Pod has the same number of bunks (25 two-person bunks), that the bunk beds in each Pod have the same dimensions, and that the bunks are placed slightly closer to each other in B Pod than C Pod (2 feet compared with 2 feet, 4 inches). Although the photo was taken before

my detention at Yuba County Jail, it accurately shows what the bunks in B Pod looked like, their layout, and their proximity to each other as of the time I resided in B Pod.

I, Gilberto Pablo Perez, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Oakland, California.

Date: May 19, 2020

//s// Gilberto Pablo Perez

Gilberto Pablo Perez

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Erica Ramos, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Gilberto Pablo Perez in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 19, 2020 I read the foregoing to Gilberto Pablo Perez and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Gilberto Pablo Perez because the location where he is in quarantine is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 19, 2020

//s/ Erica Ramos
Erica Ramos

Exhibit A



WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
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DAVID JENNINGS, Acting Director of the
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Enforcement; U.S. IMMIGRATION AND
CUSTOMS ENFORCEMENT; GEO GROUP,
INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF JOSE PABLO
GARCIA MONTES DE OCA IN
SUPPORT OF PETITIONERS-
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF JOSE PABLO GARCIA MONTES DE OCA

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Jose Pablo Garcia Montes De Oca. I was born in Mexico and I am 22 years old. I arrived in the U.S. when I was only 2 years old and was a DACA recipient.

3. I have been detained at Mesa Verde Detention Center in Bakersfield, California since February 13, 2020.

Lack of Social Distancing While Sleeping

4. I am currently in A Dorm, where there are 50 bunk beds and about 46 people right now. When I got here, there were a lot more people. About two months ago, I noticed that officials started releasing and removing some people. About a month ago, officials started moving those of us still detained to different bunkbeds. Now, there is one person in most bunkbeds but there are about three bunkbeds with a person on both the bottom and top bunk. Recently, officials also staggered our sleeping arrangements, so every other bunk has someone on top, and the same with the bottom bunks. I am currently on the top bunk, 39-up. The bunkbeds are very close to each other, there is less than three feet between the beds. And even though our bunkbed assignments are staggered, there is still not five feet between me and the person on the bottom bunk next to me.

5. I recently heard officials say that they were going to move some of those people sharing bunks to B Dorm.

6. I am the representative for A Dorm. This means that officers communicate rules to me or anything else that is happening, and I am the person responsible for telling all the detainees what is going on. On Friday May 15, the Chief at Mesa Verde told me to tell people in A Dorm that people in odd bunks are supposed to sleep facing one direction, and people in the even bunks are supposed to face the other direction. For example, if the person in bed 1 lays on his right and faces right while he sleeps, then the person in bed 2 has to sleep on his left side and face left when he goes to sleep. I laughed because that is impossible. I can tell and did tell

detainees to do it, but I do not think it makes sense. People move around in their sleep, some people sleep on their backs, and have to get comfortable. I told everyone in Dorm A to do this and they said they would try. But I know that this will not protect anyone from contracting the virus and there is also no way to enforce this new rule.

7. Since I first announced the new rule to people in A Dorm, I have not seen anyone do this. And even if everyone did this and did not move while they were sleeping, I still do not think there is enough space between me and the person in the bed next to me. For example, I have to get down from my bunk to go to the bathroom or watch TV or do anything. As soon as I get down from my bunk, I am immediately too close to the person in the bunk next to me. There is certainly not 6 feet between us—not while we sleep and certainly not when I have to get down from my bed for any reason.

8. Whichever way you go, it feels like you cannot be more than six feet away from someone's bunk.

Lack of Social Distancing at Meals

9. Currently, the facility is only letting 25 people at a time go eat. But even with staggered meals, we still have to wait in a tight line, inches from people, to leave the dorm and go to the dining hall. There is no distancing at all. It does not matter that we each sit at our own table to eat because we are only in the dining hall for 10 minutes. It is so rushed now, because they are taking us in smaller groups. We have to eat so fast it gives us stomach aches.

Lack of Social Distancing During the Rest of the Day

10. At all times, all detainees in Dorm A are within inches or a few feet from each other. If we wait for the bathroom, we are close to each other. If we are waiting in line to go to the dining hall, we are close to each other. If we are in bed, we are close to each other.

11. In the back of the dorm, there is a small area with three small tables, one microwave, a sink, a hot water dispenser, four phones and three computers. With all of these items in one area, people often congregate there to use them even though the space is really small. For example, when I am on the phone, there is maybe five feet between me and the tables where people are sitting or playing games. It is not possible to remain 6 feet apart in such a small

space where people are often coming and going to use the microwaves, phones, computers, and small tables.

12. The three little tables are bolted to the ground and are about the size of card tables. There are no chairs. Every bunk is assigned to two plastic chairs and people drag those chairs to the table to sit down. People sit at those small tables together to eat or play games. There are sometimes four or five people around one little table at the same time. The three computers are attached to one surface and are right next to each other. When people sit to use the computers, they are almost touching elbows.

13. The food provided by the facility is trash so a lot of us depend on the commissary to purchase food items. This also means that many of us use the microwave and hot water dispenser to prepare our commissary meals. A lot of people are touching the microwave and the hot water dispenser, and this makes me nervous because I see that a lot of people do not wash their hands first.

Lack of Social Distancing While Using Bathrooms

14. In the bathroom, we have two urinals and three toilet stalls, and 5 showers. There are two of these main bathrooms in the middle of the Dorm. Around May 11 or 12, officials turned the water off in one urinal, one toilet, three showers and four sinks in each of the two bathrooms. Now there is only one urinal and two toilets on each side. I believe they did this to try to create some distance between us when we go to the bathroom. But now, there are less toilets and showers so, when people want to use the bathroom or take a shower, they get in line to wait for one to open up. The fact that they turned off the water to some toilets and showers has not made things better. In fact, it made it worse, especially after yard time, when people have worked out and are sweaty and wait close together in line to shower. With less sinks, I have also noticed that people are washing their hands less.

15. In addition, there is also a small bathroom with a toilet, shower and sink on each side that is accessible for people with disabilities. But no one uses these bathrooms because they are very dirty and unhygienic. We do not clean them because it is hard for us detainees to get cleaning supplies, and so we try to conserve our cleaning supplies.

New Arrivals

16. I have also noticed that there are new detainees coming into the facility. I believe some of these people have recently been transferred to Mesa Verde from jail or state prisons in Delano, Lerdo, or Wasco, California. On May 9, a new person came to Dorm A from the Lerdo Detention Facility in Bakersfield, California. He told me that, when he arrived at Mesa Verde, officials asked about whether he was experiencing any COVID-19 symptoms, checked his temperature and then placed him straight into Dorm A. He was not quarantined before being introduced to the general population despite having arrived from Lerdo Detention Facility.

Problems with Issuance and Use of Masks

17. I think it was about a month ago that guards first distributed masks. The guards told us to wear the masks if we wanted to. They have never told us to wear them all the time. Guards give out new masks three times a week. They do tell people to wear our masks when we go to Court. No detainees in my dorm wear masks when we are in the dorm or when we go to the yard. Some guards will tell us to wear our masks to go to the phone room, but most do not. If the guards told people to wear our masks, I think detainees would follow those instructions. But no one has told us to wear the masks.

18. There are a lot of security guards who do not wear masks. Only some of the guards wear them. Once, my attorney came to visit me and was turned away because he did not have an N95 mask. But the guards do not even wear their surgical masks all the time.

19. I have heard on the news that everyone in the U.S. is now encouraged to wear face masks but people working at Mesa Verde donot wear masks. This concerns me because I know that staff come in and out of the facility and could bring in the virus. By not wearing facemasks, I know that they are potentially exposing us to the virus.

Symptomatic Detainees and Lack of Access to Healthcare

20. In Dorm A, there are always people coughing. My neighbor wakes up every day coughing. He has been like that for a long time, and he got checked out by medical staff at the facility about two weeks ago. They only gave him pills. From my understanding, when someone is sick, medical just checks people's temperature and takes their blood pressure. That is it. I am

afraid there might be people sick here with the coronavirus. Because of my health conditions, I have a weakened immune system, and I know that I am more susceptible to catching any disease.

21. My understanding is that, if someone is really sick, they have to submit a kite to request care. In my experience, it can take two or three days to get a response and it does not matter if the person is really sick or if they are older. Staff here do not seem to care. They also do not work Saturday or Sunday, so if someone is really sick, they have to wait until Monday. Even when someone does get a response to their kite request, it seems like all medical does is take someone's temperature.

22. I recently overheard two guards talking about someone in my dorm who was feeling sick, he had a bad rash all over his neck and chest, and they said that he was just whining and complaining. It took at least a week for them to give that person medical attention. From my recent experience, when you go to medical, the care is very basic. In my experience, medical staff say they cannot do much to help. Mostly they give out ibuprofen and tell people to get medical attention when they get out of detention. For example, I have a cavity in a back tooth, and a big hole. It is very painful. Medical staff told me they cannot do anything about it because of the pandemic, and just gave me ibuprofen. They told me that I should just get it fixed when I get out of detention, and that I should eat on the other side of my mouth for now.

Conclusion

23. Even if I tried to stay 6 feet away from people, it is impossible to do that here. I could stay in my bed all day and not move, and I would still be less than 6 feet from someone. Because of the existing conditions here, I am really scared that there will be an outbreak. It only takes one person in here to get sick for the rest of us to be potentially exposed. I do not see a way to prevent it unless we are released from detention and allowed to properly quarantine in the home of our family members.

I, Jose Pablo Garcia Montes De Oca, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Bakersfield, California.

Date: May 18, 2020

//s// Jose Pablo Garcia Montes De Oca
Jose Pablo Garcia Montes De Oca

CERTIFICATE OF AFFIRMATION

I, Theodora Simon, certify that on May 18, 2020 I read the foregoing to Jose Pablo Garcia Montes De Oca and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Mr. Garcia because the Mesa Verde Detention Center is located approximately five hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCÉDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF JOSE MEJIA
ROSAS IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF JOSE MEJIA ROSAS

I, Jose Mejia Rosas, declare the following based on my personal knowledge:

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Jose Mejia Rosas. I was born in Quantemo, Mexico and I am 37 years old. I have been in the United States since 1987 when I was only 4 years old. I have been a legal permanent resident since 2005.

3. I have been detained at Yuba County Jail (“YCJ”) in Marysville, CA since August 8, 2019. At YCJ, I am housed in the K Tank. Before, I was in L Tank and before that I was in the G Tank. Currently within our tank, I am housed in an open-door setting, meaning we have no doors or no barriers separating us from the inmates housed in the same tank. We have an open space with ten bunk beds, one shower, three toilets, three sinks, one long dining table and a recreation space to watch television. Everything is within the tank: we eat here, we shower here, and we have recreation time here.

Lack of Social Distancing While Sleeping

4. K Tank is a small area with the capacity of 20 inmates max, which makes it impossible to be six feet apart. As of a week ago, there were eleven detainees in K Tank. There are still 11 detainees as of the signing of this declaration. The bunkbeds are about a foot apart from each other, which means we all sleep very close to each other. For example, when one person is asleep and their feet are sticking out of the bed, their feet are about 6 inches from the next person’s head in front of them.

5. Currently, there is a bunk bed next to mine and another in front of me. Both bunkbeds are occupied by someone. If I look to my left, I can almost touch the person across from me with my hand. We are all approximately 2 feet or an arms length apart from each other when we are sleeping in our bunkbeds.

6. Because there are 11 people in K Tank, all 10 bunkbeds are occupied. Currently, two people are sharing one bunkbed—one person is on top and the other on the bottom bed. But

this is a new development because, a little over a week ago, all of the bunkbeds were full. I know that officials moved at least two detainees who suffered from asthma¹ out of K Tank and I believe a few other detainees were also moved. I do not know exactly where they were moved to, but I do believe that they are still at YCJ. I have heard from other detainees that they were moved to Q-5. I also heard from another detainee who was recently in medical that one of the people moved out of our tank is now in an A-Pod, which I believe is the administrative segregation unit.

Lack of Social Distancing at Meals

7. During mealtime (“chow-time”) we all eat at the only long table at the same time. When its time to get our food we all stand together and form a line. While in line, we are about 1 to 3 feet apart from each other. We cannot stand farther apart from each other. I have not seen the facility make any changes to keep us apart during mealtimes.

8. Even if they wanted to, I do not think there is much that they can do to create more distances between us because the areas are so small. For example, the dining seats are approximately 7-8 inches apart and we are practically elbow-to-elbow during all three of our meals. The dining seats are welded on to the tables and the tables are bolted to the ground. We all eat together at the long table in K Tank for every meal. Meals are not staggered so we are all very close to the person next us when we eat.

9. When the food is served, the officer brings it in one cart and the beverage in a second cart. They bring the food in a big metal cart and they bring the Kool-Aid in a plastic cart. The carts are wheeled in. The same cart is being wheeled in from one tank/pod to the next. At YCJ, there is approximately one food cart and one beverage cart per floor. One food cart goes into every tank/pod on the same floor. For example, K tank is located on the same floor as approximately 14 tanks/pods, including the women’s tanks. This means that the same cart goes

¹ I believe they had asthma because the nurses would come in daily and give them an inhaler twice a day. Other times, when their breathing was really bad, the nurses would take them to medical and put them on a breathing treatment for about an hour. And the detainees also told me that they had asthma and were taking medication for it.

in and out of different tanks/pods without sanitizing or wiping down between each meal drop-off.

10. When the officers bring the food to us, they are about a foot away from the cart and us when they are serving us our food. This really scares me, because I know my health is at risk and there is no way they can protect me or the other detainees when they are getting this close to us. This facility does not have enough protective measures and I feel like I am going to die in here. I already served my time and I want to be home with my family.

Lack of Social Distancing During Recreation

11. Recreation takes place within our tank. It is in one open space. The size of the recreation area is maybe 8 feet by 20 feet. We all have recreation time in the same area at the same time. In the recreation area, we are all about 2-3 feet away from each other. If we are watching a movie, we are all about a foot in half apart from each other. Because the TV is so small and the volume is so low, we all end up inches from each other as we all try to get as close as possible to the TV.

12. We also have an hour a day, five days a week of “roof” time. This means that we are allowed to go to the roof to be outside. There are pull-up bars and a basketball court there. The entire tank can go at the same time and there are no other people from other tanks there when we go. We are all touching the same pull-up bars, basketballs, and surfaces that other people in other tanks touch. I do not believe those are wiped down in between “roof” time for different tanks.

Lack of Social Distancing During the Rest of the Day

13. There is a detainee in K tank that is over 60 years old and he has limited physical mobility. When he sits on the bed to try to put his socks on, he asks one of us to help him put on his socks because he cannot reach his feet. This means that we are touching him because there is no one else who can help him.

Lack of Social Distancing While Using Bathrooms

14. Inside our tank we only have one shower. The shower has a plastic curtain as a divider and there is no privacy. When I get out of the shower, there is often someone eating

about 3 feet away from me or someone watching TV or playing a game of chess. There is almost always someone in front of me when I get out of the shower because the shower is about 3 feet away from the dining table and 3 feet away from the recreation area. It is also only about 3 feet from the main toilet in our tank.

15. As much as I would like to remain at least 6 feet from other people, it is simply not possible in our small tanks. Even the toilets are in an open aired space and do not afford any social distancing, let alone privacy. There is no curtain or anything blocking the toilets, everyone can see you go in and sit down at the toilet. And when you get up from the toilet, you are within a few feet from everyone in the tank.

New Arrivals

16. The only change I have recently noticed is that there has not really been any new detainees introduced into my tank. Before the pandemic, it was almost automatic that as soon as one person left, another person would come in the next day and take their spot. However, since around March or April, I have noticed that new detainees are quarantined in a separate room, which is in the new area of the facility that has a two-cell tank. I believe they are quarantined together for about 14 days, but I do not know for sure. Once the new inmate has been cleared by staff, they are introduced into the general tanks/pods. Again, I do not know this for sure, but I have spoke to at least one detainee who was quarantined for 14 days and have also heard officials say that this is the procedure.

17. I do believe that there have been new detainees who have been booked into YCJ. I believe these new detainees were transferred in from state prisons, jails, or picked up from the streets.

Problems with Issuance and Use of Masks

18. A little over two weeks ago, officers at YCJ began to hand out handmade face masks that had been made and donated by a local community organization. These were not masks procured by ICE. We were each handed a mask and, every Wednesday, officers come around asking us if we want to exchange our masks for a new mask. When we received the masks, officers did not provide an instructions or guidance on how to use the masks or when we

should wear them. As a result, some of us wear them and some do not. To my knowledge, it is not mandatory for us to wear masks and I do not know of anyone who has been required to wear the mask.

Lack of Proper Hygiene and Sanitation

19. We are responsible for cleaning our own tanks and common areas with the limited supplies that YCJ provides us. We are only given a mop, broom, and a cleaning tile solution for the shower. Despite our rigorous attempts to clean and scrub, the materials YCJ provides us are not enough for the deep and sanitary cleaning our tank requires in order to protect everyone from the virus. Even though we try to clean, our tank often remains dirty and unsanitary. The floors are in dire need of a good pressure wash. The paint in the facility is also chipping off from the walls, bars, and tables.

20. I am also concerned with the improper air circulation. I often see lint and even hair in the air coming from the AC unit. The AC circulates between all tanks/pods. When the AC goes out—which does happen—I can see the walls sweat with toxic water and there is a really bad smell. This really makes me feel uncomfortable and scared that I may get sick from simply breathing the air.

21. Given the limited cleaning supplies we are provided, we are also not able to adequately clean the showers and toilets. As much as we try to clean and scrub, the toilet by the shower smells like urine all the time. To make matters worse, the toilet is about 2 to 3 feet away from the table where we all eat.

22. In our tank, there is only one phone for all of us. Given the pandemic and cancelation of social visits, everyone is now using the phones more frequently. This means that we are all touching the same phone all the time—placing our mouth near the receiver. Within the last two weeks, officers gave us paper towels and detergent spray to clean the phones or any other area, but it is not sufficient.

Conclusion

23. The general mood in the tank has been stressful. No one is able to have any visits and people are worried for themselves and their families. Everyone is moody, people are scared,

worried about catching the virus, worried about their family, kids, and what is happening in the outside world. I feel we are being treated unfairly at YCJ because officials are not taking proper and necessary precautions to protect the facility from an inevitable outbreak. All detainees here know that the officials are not taking this seriously.

24. The danger and risk of being infected with the virus impacts my willingness to continue fighting my removal case. Sometimes, I feel like giving up. I have spoken to other detainees who were removed from the United States and its clear that they felt forced to sign their removal orders because they were scared and did not want to die here if an outbreak happened. I am also scared and fear for my life. The conditions here are dire and we are all scared for our lives. We need immediate changes and protections. We need to be with our families during these times and be able to adequately quarantine and shelter-in-place. YCJ is not the place where we can do that.

I, Jose Mejia Rosas, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 18, 2020

//s// Jose Mejia Rosas
Jose Mejia Rosas

CERTIFICATE OF AFFIRMATION

I, Angelica Salceda, certify that on May 18, 2020 I read the foregoing to Jose Mejia Rosas and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Jose Mejia Rosas because Yuba Detention Center is located approximately three hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Angelica Salceda
Angelica Salceda

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
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ANGEL DE JESUS ZEPEDA RIVAS,
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CUSTOMS ENFORCEMENT; GEO GROUP,
INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF JUAN AGUILAR
CASTANEDA IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF JUAN AGUILAR CASTANEDA

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Juan Aguilar Castaneda. I was born in Mexico and I am 38 years old. I have been in the United States since I was seven years old, around 1988. My mom and my siblings are all here in the U.S.

3. I have been detained at Yuba County Jail in Marysville, CA since approximately April 15, 2020.

4. At Yuba County Jail, I am currently housed in G Pod. Before, I was in F Pod for 14 days after being transferred from Monterey County Jail.

Lack of Social Distancing While Sleeping

5. I was in F Pod for two weeks. In F Pod, there are cells on two floors, 20 cells in total. While I was there, all the cells were occupied. Most detainees were in a cell by themselves, but sometimes there were two people in a cell, when it was really full. I estimate while I was in F Pod, there were maybe 8 people sharing cells. Someone new came to F Pod or left every three days or so.

6. Each cell had a small bunk bed, a toilet, and a sink. There was also a small metal table and bench, welded to the floor. The side of the cell that looks out into the Pod is made up of metal bars, so it's open air. The cells are small. Laying on my back, if I stretched out my arm, I could touch the wall of the cell. There was only a bit of room between the bed and the bars. When there were two people in a cell, it would be impossible for them to stay six feet apart. The cell just isn't big enough.

7. Around May 1, I was transferred to G Tank. In G, at first there were eight of us. Now, there are fourteen of us of us, ICE detainees and county inmates. One side of G is all metal bars. You can see everything that is happening in the hallway. There are ten bunk beds, so everyone is in their own bed. In the middle of the bunks there is a long table with benches. The benches are attached to the floor and the tables. We cannot move the table. We cannot move the

beds. Even though I don't share my bunk bed, when I'm lying in bed, if I stretch out my arm, I can touch the bed next to me. I can reach out and touch the other person. And if someone walks between the beds, it's even closer. My bed is maybe a meter and a half, at most, from the dorm door.

8. All of the other detainees walk by G to get to the yard. So there are people walking by me maybe once an hour, they walk very close to the metal bars and to us. There have been people coughing as they walk by G. My bed is only three or four steps from the hallway. When I'm laying down at night, people who are walking through the halls are quite close to my head.

Lack of Social Distancing at Meals

9. In F Pod, meals were brought to our cells. Officers came by with a meal cart and handed us trays one by one. We ate in our cells. The officers did wear masks and gloves.

10. In G, food is brought by officers. Sometimes officers come, open the door, and hand the food to us through the door. We stand in line. We are one after another in line. There are other officers that pass the trays to us through the metal bars. And they give a tray to each person. Then we all sit at the table, all fourteen of us, to eat. Our elbows bump when we sit down to eat.

Lack of Social Distancing During Recreation

11. The only places to sit are beds or the benches at the table. People are pretty close to one another, walking or at the table. It's about three or four steps from my bed to the table, maybe 1.5 or 2 meters apart. So our beds are pretty close to the only common area. Wherever you go, you are always near another person.

12. It is not possible to socially distance in G Tank. There just isn't enough space. We feel like rats in a cage. When people walk through the Tank, we're almost always should to shoulder.

Lack of Social Distancing While Using Bathrooms

13. In G Pod, there is one shower stall, with a curtain. That shower is shared by all nine people. The shower and toilets are cleaned every day by the detainees. There are three

toilets, in a row, that are maybe three feet apart. There is a small separator between the toilets, but no door. So even while you go to the bathroom, you can't get away from other people.

14. In my cell in F Pod, the toilet was really dirty. I tried to clean it, but I could not get rid of the smell. It was like it had been too long since it had been cleaned. And the water from the sinks was really disgusting. It tasted dirty, like rust. It did not seem like safe water to drink, but that was the only water we had for drinking. We got a tiny bar of soap maybe twice a week.

Lack of Proper Sanitation and Hygiene

15. When I first arrived at Yuba, no one at the facility told me anything about the coronavirus or how to protect myself. The screening process was questions about my physical health and medical background, like if I had ever been in the hospital. They asked if I had any COVID symptoms and took my temperature and pulse. I was not given a test for the coronavirus.

16. They did not give me a mask, but I kept the one I brought with me from Monterey County. But I had been using that mask for over a week by then. Yuba did not give me a mask for about three or four days, and did not tell me how or when or where to use it or give me any other instructions.

17. Everyone in F Pod used the same phone. I could see the phone from my cell, and I saw that many people did not clean the phone before they used it. The cleaning supplies were not near the phone. Many people just picked it up and held it close to their face to talk.

18. There is not enough soap in my current dorm. When we run out, we ask the officers, but it takes them a long time to bring more. My soap has run out many times. Last week, I had to wait for three days for them to bring more soap, even though I continued to ask for soap. The officers told us to wait, that they would bring more soon. I would guess that probably four of us had run out of soap.

19. To buy soap in the commissary is like \$3.50. My mom sometimes puts money on my commissary account, but since she is not working right now, she cannot afford much. My stepfather works at a golf course, and he has not been working because of COVID-19. \$3.50 is too much for me, and since my mom does not have a job right now, I try not to spend much

money and use my commissary account to call and check in on her. It does not feel right that I do not have enough soap just because I cannot buy it. Sometimes people leave soap in the sink, after they take a shower, and I try to use that soap when I run out.

20. I went to use the private phone room on April 30th. It is dirty in the phone room phone booth. There is a lot dust and grime, it does not seem like they clean it. There are no cleaning supplies in the room, there is no way to wipe down the phone. I felt uncomfortable because I could not clean the phone and I put it up to my face. I do not know who was there before me, and that is scary. I do not know if that person was sick and could infect me.

New Arrivals

21. I was worried that the new people coming into F Pod every few days would bring the disease in, and that I would get sick. I was afraid of getting sick and not being able to do anything about it. I also worried that I would get the disease from a new transfer and not know it, and then I could get others sick, too.

22. When they would remove someone from a cell, sometimes they would clean the cell, and sometimes they would not. And their cleaning was to spray bleach, and that was all. There was at least one time where there was a new person in an empty cell within an hour of the old person leaving.

Symptomatic Detainees and Problems with Healthcare

23. While I was in F Pod, there was one person who got really sick with COVID symptoms. For three straight days, he was coughing constantly, hard. He was only a few cells away from me. When he would walk by my cell, like to go to the shower or use the phone, he was certainly less than two meters away. And the cells do not have doors, just bars. When he would walk past my cell, and all the cells, he would be coughing. I remember seeing him use the phone, since my cell was directly across from the phone, and I do not remember seeing the phone cleaned after he used it. He was removed from F Pod after three days. I do not know where they took him or what happened to him. I was worried he would get me sick. This made me feel afraid. When he could not figure out how to use the phone, he would come over and ask

me how to use the phone and he would not have a mask on. He would ask me for help, and he would cough.

24. When I got to G, there was a county inmate here that was coughing, and he was coughing frequently and hard. I think he submitted a medical request but did not go see a doctor.

Problems with Issuance and Use of Masks

25. In F Pod, I only saw people use their masks when they left the housing unit, when they were going to talk with their lawyer, or to see the nurse.

26. I have never seen anyone in G use their mask while they are here in the dorm.

27. We go to the roof maybe three times per week. We go all together. We do not put on masks, and we are not told to. We walk in a single file line; I could touch the person in front of me if I wanted to.

28. It seems risky and dangerous that the guards are going in and out every day. They go outside, and we do not know where they go. And then they come back, and we have a lot of contact with them. They are around a lot. They could get us sick. That scares me. They could spread the virus without knowing it.

29. It is not possible to socially distance in G Pod. There just is not enough space. The facility has not given me any information about coronavirus. They have put up a flier, but they do not talk about it. I have not been told to wash my hands frequently or how important it is to maintain social distance. I only know this because we watch news. The TV with news is almost always on.

I, Juan Aguilar Castaneda, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 19, 2020

//s// Juan Aguilar Castaneda
Juan Aguilar Castaneda

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Theodora Simon, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Juan Aguilar Castaneda in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 19, 2020 I read the foregoing to Juan Aguilar Castaneda and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Juan Aguilar Castaneda because Yuba Detention Center is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 19, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF JUAN JOSE
ERAZO HERRERA IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF JUAN JOSE ERAZO HERRERA

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Juan Jose Erazo Herrera. I was born in El Salvador and I am 20 years old. I have been in the United States since I was 16 years old. I am seeking asylum.

3. I have been at Yuba County Jail for 26 months. At Yuba, I am currently in an Administrative Segregation unit by myself because I went on hunger strike. I went on hunger strike because the conditions here are dangerous. I was in D Pod for a long time, and on May 8, 2020, I was moved to H Tank.

Lack of Social Distancing While Sleeping

4. I was in H Tank for about two or three days. H Tank was too small for us to engage in social distancing. There were 10 people crammed into the tank. It was impossible to be six feet away from other people.

5. In H Tank, there were ten bunk beds, with space for 20 people. There were four bunks in a row on one side, and six bunks in a row on the opposite side. The bunk beds are welded to the wall or to metal bars that separate the two groups of bunk beds. The entrance to the dorm is metal bars with air flowing through. We slept next to the wall, and our heads were all towards the hallway where people walked by. We slept head to toe with other people in adjacent bunks. Two of the bunk beds had two people in them, the rest were singles. All the lower bunks were taken. While lying in bed, I could almost touch the person's head in the bunk bed behind me with my toes. In my bed, I had a bunk bed on my left side, as well as at my feet. All of this was true up to the day I was removed from H Tank on about May 11.

Lack of Social Distancing at Meals

6. There is a long table in H Tank where we would all eat. It is maybe big enough for 16 people. When we sat down to eat, our legs were touching. And at one end of the table, there was a little TV. There were single seats at the table. They were attached to the metal table with steel. The table is welded to the floor. These were the only places to sit in the whole dorm.

You were either in your bed or sitting at the table. For example, on Mother's Day afternoon, most people were watching TV at the table and we were all within six feet of each other. Only the person in his bed and the person showering were farther away.

7. At mealtime, the officers would come by with the food cart. There were some officers who made us get in line behind a line of tape they put on the floor to keep us distanced from the guards, and come, one by one, to the door to get our tray at mealtimes. There were officers that did not care about social distancing and did not care that we detainees were on top of each other as we waited for food. But even when we stayed behind the line, we were standing inches from the other person. We all sat at the table to eat, at the same time together, and we were just too close to one another. We were side by side because the table is not very wide. When we would eat, my tray and the tray of the person in front of me would touch.

Lack of Social Distancing During the Rest of the Day

8. When we were moved from D Pod to H Tank, the county inmates who had also been in in D Pod with were moved to the tank next to us, which is even smaller than H Tank. I could see the county guys on my way to the yard. Their tank also has bars. At Yuba, there are four tanks in a row, all with bars; so, the air flows between the tanks, we all breathed the same air.

9. While in our tank, we could see staff and people in detention as they walked by. And we were all breathing the same air. People from all the dorms walked by H Tank at all hours of the day. They were usually not wearing masks. When I would lay down at night, my head was only about four steps away from the hallway, where people were walking. When officers walked by at night with the garbage, or from one housing unit to the next, they would wake me up. It is like those people were in the tank with us.

10. All ten of us were together in H Tank for 23 hours a day. The only time we left that small space was for yard time, for an hour a day. Sometimes people would go to medical or to use the phone room, but otherwise, we were all packed together, where it is impossible to practice social distancing.

11. Even when we walk to the yard, we walked in a line like a train, one after another. We were not six feet apart.

Lack of Social Distancing While Using Bathrooms

12. In H Tank, there was one shared shower. There were three toilet stalls each with a metal toilet bowl and a small metal sink. The toilets did not have doors. It was really uncomfortable because everyone could see you, and when someone else was in the bathroom you could hear and smell everything. We hung a sheet up to try to have some privacy. But the officers would take the curtain down. All ten of us were breathing the same air and using the same bathrooms.

Problems with Issuance and Use of Masks

13. Community organizations on the outside made handmade cloth masks for us and sent them as donations. It is not fair—ICE should have given us masks and protected us. It is nice that these community groups came together to help us, but really that was ICE's responsibility. They are cloth masks, but I am not sure if they really work to protect against the virus. We do not use the masks. Once a week, officers bring us a mask that someone else was using before and claim they cleaned it. They do not tell us to use the masks here. Officers have only told us that we have to put our masks on when we go to Court. But when we use the phone room or go to the yard, no one tells us to use the masks, so we do not use them.

Lack of Proper Hygiene and Sanitation

14. I feel that the most likely way we get COVID-19 is because of staff. The nurses and the officers go outside and go home, and we do not know what they do. Then they come here and work. In H Tank, an officer came once an hour to do the check down. The officer walked between us and was very close to us, much less than six feet. I have seen a few officers without masks, but most of them do wear masks. While some officers wear gloves, some do not. The officers and staff are not practicing social distancing while at work. The same officers also go to F Pod, where all the sick people are, and then they come and walk by our dorms. Who can say that they are not contaminating us? If they are not willing to follow the rules, how can I demand that they take precautions to protect us? They do not take us seriously or listen to us.

Conditions Are Getting Worse

15. Since my attorney Kelly Wells submitted a declaration on my behalf in *Bahena Ortuño* on March 30, 2020 (3:20-cv-02064 Dkt. 26-13), nothing changed until the Judge ordered release of a few people. Only then did officials pass out masks and started spraying bleach on the floor sometimes. But social distancing is exactly the same as it was before.

16. After the *Bahena Ortuño* lawsuit was filed, officers started giving us soap every day. But that stopped after a week or two, and now we are back to getting the little soaps two times a week and they just do not last. When I got to H Tank on May 8, there was no soap at all for at least three days.

17. We are more exposed to the illness here than we were before. On Sunday May 10, 2020, I decided to go on hunger strike because of these conditions. I want to change to happen. I have been locked up a long time. People do not want to give us the chance to make it. ICE is exposing me to this illness, and they just do not care. ICE says we are a danger to society, and that we are protected from the disease. We are not a danger; we are *in* danger. We are in danger here because we could get sick at any moment and they are putting us in greater risk. For me, deciding to go on hunger strike is not just for me. I am doing it for everyone here. My voice is not just for me. I want people to realize that this just is not me and that everyone here is in danger. We are not safe.

18. ICE officers threatened to transfer me to another facility to get me to stop my hunger strike and tried to bribe me with free calls to my family if I stopped, but I refused. They placed me in a freezing cell where I was alone 24 hours a day, except for brief visits with medics. Despite the threats, hunger, cold, and isolation, I continued my strike from the morning of Sunday, May 10, until Saturday night, May 16, when I stopped my strike. But my fight is not over. I learned from my lawyer that many organizations asked officials to investigate the situation here due to my hunger strike, and I will keep fighting until we are all free, which is the only way we can protect ourselves from this virus.

I, Juan Erazo Herrera, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 20, 2020

//s// *Juan Erazo Herrera*
Juan Erazo Herrera

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Theodora Simon, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Juan Erazo Herrera in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 20, 2020 I read the foregoing to Juan Erazo Herrera and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Juan Erazo Herrera because Yuba Detention Center is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 20, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
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JERONIMO, CORAIMA YARITZA
SANCHEZ NUÑEZ, JAVIER ALFARO,
DUNG TUAN DANG,

Petitioners-Plaintiffs,

v.

DAVID JENNINGS, Acting Director of the
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ALBENCE, Deputy Director and Senior
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of the U.S. Immigration and Customs
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CUSTOMS ENFORCEMENT; GEO GROUP,
INC.; NATHAN ALLEN, Warden of Mesa
Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF LIVIA
PINHEIRO IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF LIVIA PINHEIRO

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Livia Pinheiro. I was born in Brazil and I am 40 years old. I have been in the United States since I was about 7 years old. My two children and parents are U.S. citizens.

3. I have been in ICE detention since October 25, 2017. I was initially placed at Yuba County Jail. On August 2, 2018, I was transferred from Yuba to the Adelanto Detention Facility. On January 17, 2020, I was transferred back to Yuba.

4. When I returned to Yuba in January 2020, I started out in R dorm.

Lack of Social Distancing While Sleeping

5. In January 2020, R dorm had 18 people. On May 7, a guard told me that more people would be added to R Dorm from other tanks and, at the time I was transferred out of R dorm on May 9, there were 11 women total, both ICE detainees and county inmates.

6. There are nine bunkbeds in R dorm set up right next to one another, about two feet apart. I was in the lower bunk to the left as you first entered the R Dorm, up against the wall. When I slept, if I reached out, I could definitely touch the person next to me. She was just a couple of feet away from me.

7. It is impossible to stay six feet apart from other people with this set-up.

8. The R dorm does not have any windows. There was one small fan in the room that was connected to the wall outlet. There were also two suction fans that seem to recirculate air between the dorms. I think this because the smells of cigarette smoke, marijuana, and burning food from the kitchen drifted into R dorm.

Lack of Social Distancing at Meals

9. In the middle of the R dorm, there are three tables, each with six chairs. The three tables were right in a row. The tables and chairs are bolted to the ground and cannot be moved. Everyone who lived in the R dorm ate at the same time. Although all of the seats at the tables

were not full, we were still very close to each other when we ate. Sometimes while eating, I would touch shoulders with the person sitting next to me. If a woman was sitting across from me at mealtime, she would be no more than three feet away; I could reach out and touch her.

10. At mealtime, the guards rolled the food from the kitchen on a metal food cart. They would stand outside the dorm door and pass out trays or let the women pick up their own trays. In late March, one of the guards placed tape on the floor to keep a six-foot distance between the officers and where women lined up to be called for their meal. But we were still close to one another while standing in line. And it did not seem like the guards cared about social distancing. Even after the tape was placed on the floor, there was one officer who would allow one woman to stand next to the food cart and hand out trays to the other women.

Lack of Social Distancing While Using the Bathroom

11. There were two shower stalls in R dorm. The stalls were very close together and when you showered you were only a few feet away from the person next to you, and the only thing separating you from the other person was a moveable plastic divider that only covered up the area between your knees up to about your shoulders. There were two toilets in the bathroom, each with a sink. The toilets were only about two feet apart. When you stood up, you could see into the stall next to you. There was no privacy. If two women were going to the bathroom or taking a shower at the same time, it was impossible to stay six feet apart from one another.

Symptomatic Detainees and Problems with Health Care

12. In mid-March, a woman in R got very sick and had to be hospitalized. After that, several women, including me, got really sick. I have two underlying medical conditions: severe asthma and Reynaud's disease. Reynaud's disease causes bad blood flow and, once I get sick, my immune system shuts down.

13. When I got sick in late March, I had chills, what felt like a fever, body aches, bad headaches, sneezing fits and a severe cough. I cannot say for certain whether I had a fever because my temperature was never taken. I had to use my inhaler every few minutes to help me breathe. I did not have steroids to help open my lungs because the medical staff does not allow steroids in detention (even though I am supposed to have it at all times). I was bed-ridden for

four days. I put in medical requests for two weeks straight, but wasn't seen by medical staff until I was starting to feel better. I was quarantined for two and half days in the medical dorm and, by the time they finally took my temperature for the first time, I didn't have a fever.

14. On April 3, 2020, I again requested my steroid treatment, but medical staff denied my request. Two other women, Noemi Johnson and Brenda Ruiz also got sick. The three of us all asked to be tested for COVID -19. Medical staff told us that they did not have the COVID-19 test. To the best of my knowledge, no one in the detention center has been tested for COVID-19.

15. Another woman got sick a few days before me. She was vomiting, had body aches and was coughing, and a high temperature. But the officers still made her go to work in the laundry area.

16. On April 17, 2020, I went to see the doctor. I had been feeling pain in my breast. The medic did a breast examination and found two lumps under my armpit, two lumps on my left breast, and three on my right breast. When I requested a mammogram, the medical staff acknowledged that my exam was concerning, but that I could not go outside of the detention center for further testing due to COVID-19. It wasn't until my immigration attorney advocated for me that I was finally taken to a Sutter Health hospital on May 13, 2020 for a mammogram. During that month of waiting, I was really afraid that I might have cancer and I was so anxious to get tested but they kept telling me I couldn't.

I am Being Punished with Solitary Confinement for Discussing My Medical Vulnerability

17. I suffer from bipolar disorder, PTSD, and depression in addition to my severe asthma. When I first got here, they did not give me my bipolar medication for several weeks and I suffered a manic episode. I was really depressed about being here, so I stopped eating. I do not know for how many days. That's when they put me in isolation the first time, in Q1. Isolation made it even worse, and I stopped eating all together. I was in the shower one day, and I fainted and fell. They had to send me to the hospital. My face was all busted open. When I came back from the hospital, around February 22, the medic said that it wasn't good for me to be by myself.

18. Sometime in late April, when we heard about *Zepeda Rivas*, we started hearing that detainees were going to be released. When I asked Officer Sodu, "Do you know if there are

any detainees being released tomorrow?” she said, “You guys ain’t going nowhere. For those of you who want to claim you have compromised immune systems, you’re going to be put in the SHU. We’re creating a segregated housing unit for you.” She said this in front of the whole dorm. Everyone understood it as a threat because of how bad the SHU is. It turned out to be true.

19. On Saturday May 9, 2020, I was moved into a segregated housing unit, Dorm T, for the second time. Officer Beatie came at about 7am on Saturday morning, May 9, and told me to pack up my stuff to be moved. When I asked her why she was moving me, she said, “These are ICE orders, its due to COVID and your health.” No one else was being moved. I asked her if I would be by myself, and she said “Yeah, just you.” I suffer from severe depression. I was really scared. I don’t do well by myself. I go into a really dark hole. I feel like I’m being punished because I am at risk.

20. After I had moved, the guard came back later that Saturday and told me, “Because you have such a high health risk, the one detainee with the highest health risk in this facility, ICE has ordered you to be completely isolated and put in segregation.” I am clearly being punished because I have a compromised immune system. On May 14, one of the female guards came by to do a check. She was wearing her mask, but it was hanging down between her neck and her chin. She said it was hot, and she did not want to smear her makeup. Then on May 16, another female officer came to do a check. While in my cell with me, and her mask not covering her whole face, she sneezed and did not even try to cover her nose. I’m not safe here.

21. The danger of COVID-19 impacts my ability and willingness to fight my removal case. When I asked about my case recently, Officer Reyes, my deportation officer, said “Ms. Pinheiro, you can pull out whenever you want, and I can get you deported right away. That’s my job.” I want to stay and fight, but I also do not want to die.

I, Livia Pinheiro, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 17, 2020

//s// Livia Pinheiro
Livia Pinheiro

CERTIFICATE OF AFFIRMATION

I, Theodora Simon, that on May 17, 2020 I read the foregoing to Livia Pinheiro and that she affirmed that it is true and correct. I have not been able to obtain a signature from Ms. Pinheiro because Yuba Detention Center is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with her, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 17, 2020

//s// Theodora Simon
Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

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Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
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emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
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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. 3:20-CV-02731-VC

**DECLARATION OF MARIA
ANDREAS SALGADO IN SUPPORT
OF PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF MARIA ANDREAS SALGADO

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in *Zepeda Rivas, et al. v. Jennings, et al.*, 20-cv-02731-VC.

2. My full name is Maria Andreas Salgado. I was born in Michoacán, Mexico and I am 31 years old. I was detained at Yuba County Jail in Marysville, California from April 25, 2019 until Monday, May 18, 2020 when I was released by order of the Federal Court. At the time of my release, I resided in R Dorm at Yuba.

3. I have reviewed the attached photograph, which I am informed was previously taken of R Dorm at the Yuba County Jail. Although the photo was taken before my detention at Yuba County Jail, it accurately shows what the bunks in R Dorm looked like, their layout, and their proximity to each other as of the time I resided in R Dorm.

I, Maria Andreas Salgado, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Windsor, California.

Date: May 20, 2020

//s// Maria Andreas Salgado
Maria Andreas Salgado

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Theodora Simon, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Maria Andreas Salgado in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 20, 2020 I read the foregoing to Maria Andreas Salgado and that she affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Maria Andreas Salgado because the location where she is in quarantine is located approximately one hours away from my home by car, and at the time I reviewed the foregoing declaration with her, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 20, 2020

//s// Theodora Simon
Theodora Simon

Exhibit A



WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
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Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF MAYNOR
OXLAJ SIGUANTAY IN SUPPORT
OF PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF MAYNOR OXLAJ SIGUANTAY

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in Zepeda Rivas, et al. v. Jennings, et al., 20-cv-02731-VC.

2. My full name is Maynor Oxlaj Siguantay. I was born in Guatemala and I am 22 years old. I have been in the United States since 2014. I am currently appealing my asylum case with the Ninth Circuit Court of Appeals and I simultaneously have filed a motion to reopen my case before the Board of Immigration Appeals because of receiving ineffective assistance of my previous attorney. With me in the U.S. is my mom, my three siblings, my aunts and cousins, and my godmother who supports me a lot. I lived mostly with my godmother in San Rafael. We got along really well, we would go out on walks together or go to the park. I hope to get out of here and go back to live with her.

3. I have been detained at Yuba County Jail in Marysville, California since April 2, 2018, over two years. In that time, I have been in A, C, E and F Pods. I am currently housed in E Pod.

4. About two months ago, I was moved from F Pod to A Pod because they said they needed to use F Pod for sick people. A, E and F pods are all set up the same in terms of building infrastructure.

5. I was in A Pod for about a month and a half. On Monday, May 4, I was moved to E Pod.

Lack of Social Distancing While Sleeping

6. In A and E Pods, there are 20 cells, 10 on the first floor and 10 on the second, and a small common area. There are bunk beds in all the cells and, when I was in A Pod and now in E Pod, most people share cells. I think there are about 29 detainees in E Pod. There is not any distance between people. I do not share a cell, so if I am in my cell, I am able to stay distanced from other people. But when we are out of our cells, we are all together in a small common space, and we cannot help but be close to one another. We rotate who is out of their cells, and it is about 15 people out of our cells at a time. We have “program time,” when we are out of our cells, for six hours a day. Otherwise, we are in our cells. The dorm is small. Social distancing is not possible here, people are just too close all the time. I feel like we are all squeezed together even when we get out of our cells. And people who share a cell are in their small cell with a cellmate for about 18 hours a day.

Lack of Social Distancing During the Rest of the Day

7. In the common space, there are four tables, two showers, the phones, and the things for cleaning—a mop and broom. About six people fit at each table. The benches and tables are made of metal and welded to the floor. When we are out of our cells, people are mostly gathered at the tables. There is nowhere else to be. So, people are sitting right next to each other, and across the table from one another.

Lack of Social Distancing While Using Bathrooms

8. There are two showers, one downstairs and one upstairs. The toilets are all in our cells, and our sinks, too. The showers in E Pod really stink, just like A Pod. It seems like the toilet water runs under the shower and it stinks.

New Arrivals

9. When I was in A Pod, I could see that there are new people coming all the time. A Pod is next to booking and I could see through a little window. I would see anywhere from two to five new people come. It does not seem right. Instead of protecting us, it is like they just do not care about our health. All of those people, they come from outside, and they could bring the virus. And they could get us all sick. And in my experience, ICE does not care about our health.

Problems with Issuance and Use of Masks

10. About once a week, they take the handmade cloth masks they give us to wash them in the laundry and hand out ones that they say have been cleaned. I feel like they are not clean when they come back. They laundry here is not good. Sometimes our clothes come back smelling. Sometimes the boxers come back with stains. What is the point of saying they are taking care of us with masks, when they do not do their jobs well to clean them? The elastic is getting worn out, too, and the masks do not stay on. They smell damp. I feel like there are people that are sick in here that use them, and then they do not do a good job washing them and hand them back out. And then we have to use them, and that makes me feel pretty afraid that I could get sick.

11. When the officers first handed out masks while I was in A Pod, they did not tell me anything. An officer just dropped the mask in my cell. No one has ever told me when to wear my mask. Some people use their masks when we go to the yard, but no one wears them in the Pod. I do not think these used masks protect us. I do not even want to use it, because I really think the mask could make me sick instead of protecting me.

12. The guards here have not told me anything about how to protect myself from getting this disease. They have not said anything to me about social distancing, and we have not been to do social distancing. They have put up posters about COVID and hand washing. The papers put these fliers up that say wash your hands, but when we ask for soap because we have run out, they don't bring it, and they just never bring soap. The posters say one thing, like "free bar of soap," but then when you ask the officers they just don't respond. So, what is written on the papers doesn't matter, because they do not actually help us.

Lack of Access to Healthcare

13. I suffer from a chronic cough and wheezing, and I have problems with my right eye and ear. When I have gone to doctor, they have told me everything is fine. It is painful, and sometimes I have to lay down during the day because it hurts so much. I have chronic bloody noses, and they say nothing is wrong. I also have been diagnosed with PTSD and my anxiety is worsened by stress.

14. Late in 2019, I got a bad cough. I was sick for over a month with headaches and a fever. I submitted many requests to see a doctor but was never taken to see a doctor for that illness.

15. Sometimes we think this illness is going to get in. What happens if we get sick with this disease? We are all physically close to one another, and I am afraid that something is going to happen to me. Here the medical staff do not help. You have to submit constant requests, and even then, sometimes you do not even get medical care. The medical staff sometimes just ignore us or get mad when we ask questions. They just do not seem to care about us. So, what would happen if we got sick? It is really worrying.

16. All of this makes me feel totally desperate sometimes. I get frustrated, and all I think about is going home. It gives me such a headache. I worry that something is going to happen to me, especially with this pandemic. I have not seen my family in two years, I have not been able to hug them. It is unbearable to think what if something happened to me here inside, and I never saw them again.

I, Maynor Oxlaj Siguantay, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 19, 2020

//s// Maynor Oxlaj Siguantay
Maynor Oxlaj Siguantay

CERTIFICATE OF INTERPRETATION AND AFFIRMATION

I, Theodora Simon, certify that I am fluent in Spanish and English and that I am competent to interpret between these languages. I further certify that I have read the foregoing to Maynor Oxlaj Siguantay in Spanish. I further declare that I am competent to render this interpretation and that I would testify to the same under the penalty of perjury if I were called upon to do so.

I further certify that on May 19, 2020 I read the foregoing to Maynor Oxlaj Siguantay and that he affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Maynor Oxlaj Siguantay because Yuba Detention Center is located approximately two hours away from my home by car, and at the time I reviewed the foregoing declaration with him, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 19, 2020

//s// Theodora Simon

Theodora Simon

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
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SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
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Verde Detention Facility,

Respondents-Defendants.

CASE NO. 3:20-CV-02731-VC

**DECLARATION OF PRAVINDAR
SINGH IN SUPPORT OF
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BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF PRAVINDAR SINGH

1. I make this declaration from my personal knowledge and, if called to testify to these facts, could and would do so competently. I make this declaration in support of the Motion for Preliminary Injunction in Zepeda Rivas, et al. v. Jennings, et al., 20-cv-02731-VC.

2. My full name is Pravindar Singh. I was born in Fiji and I am 38 years old. I have been in the United States since July 1, 1995. My wife and three children are U.S. citizens, as are my parents, two of my siblings, and my six nieces and nephews.

3. I have been detained at Yuba County Jail in Marysville, California since March 19, 2020.

4. I have suffered from asthma since I was a child. I have tested positive for Tuberculosis and am pre-diabetic. I also have nerve damage in my foot.

Lack of Social Distancing While Sleeping

5. At Yuba County Jail, I am housed in E Pod. E pod is cell living. The sleeping capacity is 40 people, with 20 cells in total. I estimate that the cells are six by ten feet. With 28 people currently in E pod, there are two people in many of the cells.

6. We sleep in bunk beds, with about three feet between the top and bottom bunk. It is a fairly small cell. Two people cannot walk around at the same time. One person has to stand against the wall in order for the other person to walk by. In each cell, there is a small metal table, a sink, and a toilet. The toilet is about one foot from my bed. When your cell mate is using the toilet, you have to push your face to the cell door because the smell is bad, and it lingers.

7. I share a cell, and my bunkie and I are very close almost all the time. I sleep on the bottom bunk. When my roommate hangs his hand from the top bunk, it could touch my face. We cannot be more than 2 ½ feet apart. When you are in the cell, if your roommate did not brush their teeth, you can smell their breath. I am locked in my cell with my bunkie for about 18 hours a day.

8. There is some kind of exhaust system, but the air that circulates within the dorm is not fresh air. The vents run through all of the cells. If there is a bad smell in the air, everyone can smell it. If someone has a virus that is airborne and that person is coughing, I do not see how it

would not circulate through the facility. The exhausts inside the cell are on top of the toilet and the blow out part is on top of the sink. The vents are about 3 feet apart. One exhaust will suck the air, and the other will release it. If I block the exhaust on one side, then air will not come out of the other side and the air flow stops. Our cell vent is clogged. We have asked staff to clean them for us, but they have not. People put toilet paper in the vents and there is dust in them.

Lack of Social Distancing at Meals

9. With one exception, nothing has changed at Yuba regarding meals since I arrived on March 19, 2020.

10. At mealtimes, we all come out of our cells and form a U-shaped line behind a piece of white tape that is on the floor. The white tape was added in early May and it is the only change I have seen in meal service since I arrived here. The white tape separates the line of detainees waiting for food from the food server, but it does not separate the detainees from each other. The first person in line is standing on the white tape. The server, the officer, and the food cart are standing six feet away from the first person in line. Behind the first person in line, the line of detainees waiting wraps into a U shape to the right so that the last person in line is next to the officer and server, and the room is so small that we can only stand about one foot apart. You could breathe on the neck of the guy in front of you. After you are given your tray, you literally have to tell the last person in line "Excuse me" so you could get by.

11. After I get my meal, I take my tray to my cell. My cell mate and I are shoulder to shoulder because the table in our cell is about 2 ½ ft by 1 ft. The table is about a foot away from the toilet.

Lack of Social Distancing During Daily Activities

12. Aside from the showers and our cells, the day room is the only space to be in E Pod. On a rotating basis, we have a total of six hours of "program time" a day when we are allowed to be out of our cells. Typically, there are between 15-20 people in the day room. The day room is about 2 1/2 car garages wide. It is fairly small. I would say maximum 20 people fit in the day room, so even though the Pod is not at capacity, the day room is still pretty full. It is not possible to be six feet apart in there. The phones, tables, and the water cooler are all in the

day room. There are only four tables for people to sit at. The tables are about three feet apart and are about five feet by two feet. Some people play puzzles on the tables. Often, there will be six people sitting at each table. This means that people are sitting shoulder to shoulder. We do not have another area where we could play, and we cannot move the tables or seats, so we do not have another choice.

13. The yard is about the size of a half basketball court. Everyone uses the same pull up bar to do pull ups and dips. This area is filthy, and I have never seen it being cleaned. We use the yard for about an hour a day five days a week.

14. The phones in the Housing Unit are right next to each other, only about three feet apart. One phone is in a phone booth that has an opening at the top and at the bottom. There are only two phones for twenty people at a time. Within your free time you are expected to shower and make your calls. Sometimes our free time is going to end and there are still people waiting to use the phone. As soon as the last person hangs up the phone the next person waiting quickly grabs the phone. I have rarely seen people wipe down the phone. The cord is one foot long, so you have to put your face and mouth really close to the phone.

Lack of Social Distancing While Using Bathrooms

15. Every cell has its own sink and toilet. We have access to two showers, one on the first floor and the other on the second floor. There can only be one person in each shower stall, so you have to wait in a line of two to three people to take a shower. Sometimes you do not get to shower because there are twenty people waiting to shower during our limited free time that occurs twice a day.

Continuous Stream of New Arrivals at Yuba

16. Within the last two months, we have had people come from it seems like everywhere: the streets, Solano, Mesa Verde, Stanislaus, Jamestown, the local Yuba county jail, Folsom prison. It seems like they quarantine some of the new people who arrive, but not everyone. On April 19, 2020, a guy who was previously at Stanislaus was transferred into my Pod. I know he was not quarantined before arriving because I asked him. He told me his current

cell mate came from Folsom prison in the last 2 weeks. When he arrived, he was quarantined for two weeks in F Pod, the quarantine pod.

Symptomatic Detainees and Problems with Health Care

17. My cell mate has breathing problems. It is hard for him to breathe. In the middle of the night, I have seen him hit the emergency call button and tell staff that he cannot breathe. Around May 4 or 5, he had slapped the button telling them, "I really can't breathe." No one from the staff rushed over to check on him. The last time I saw him struggling was the week of May 4. I do not know why he cannot breathe. Another of our podmates, who was in my neighboring cell, went to the hospital around May 8. He had some type of ear infection, but I do not know if it was related to COVID. When he went to medical, they gave him salt. He got really bad after that, so he was taken to the Chico hospital. They sent him back to Yuba, but then he got sick again and that's when he left and never came back.

Conclusion

18. Everyone is worried and scared. We do not know what is going on. This place has remained the same. The jail never explained how they are trying to protect us. The officers wear a mask, but they leave it hanging around their neck. People are scared to go to their court hearings. On April 13, 2020, I went to the ICE office in Sacramento for my immigration hearing. The ICE officers who were there were not wearing masks. The man who dialed the phone numbers for me to speak with the judge did not have a mask on. The officer who patted me down did not have a mask on, and the officer who took my temperature didn't have a mask on. There were about seven of us who went to court in a van. There were three of us in the holding cell and we were not six feet apart.

19. I am not trying to die in here. My family would not even get my body. I currently wait two weeks for medical care, so I am scared that I will get sick with COVID and die here. Other jail facilities I have been to respond within 72 hours, that is not the case at Yuba. They are not treating us properly. If one person catches COVID here, everyone will get it.

20. The risk of COVID 19 makes me want to give up, just to get out of here. The medical care here is so bad that I'm afraid that if I get sick, I am going to die in here. It makes

me want to quit fighting my case. If I had to paint a picture, I would say we are like the animals you see on the SPCA commercials. We are like sick little dogs in cages, waiting to die if someone does not save us.

I, Pravindar Singh, declare under penalty of perjury that the foregoing is true and correct to the best of my recollection. I sign this from Marysville, California.

Date: May 18, 2020

//s// Pravindar Singh
Pravindar Singh

CERTIFICATE OF AFFIRMATION

I certify that on May 18, 2020 I read the foregoing to Pravindar Singh and that she affirmed that the foregoing is true and correct. I have not been able to obtain a signature from Mr.

Singh because Yuba Detention Center is located approximately an hour away from my home by car, and at the time I reviewed the foregoing declaration with her, the county where I reside was, and remains, under a “shelter in place” order.

Date: May 18, 2020

//s// Erica Ramos
Erica Ramos

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF AKIKO
IWASAKI, PH.D IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF AKIKO IWASAKI, PH.D.

I, Akiko Iwasaki, declare as follows:

1. I am the Waldemar Von Zedtwitz Professor of Immunobiology and Molecular, Cellular and Developmental Biology at Yale University School of Medicine, where I have been a professor for the past twenty years. I am also an Investigator at the Howard Hughes Medical Institute, one of the world's most renowned medical research organizations. HHMI combines the research prowess of leading immunologists, doctors, and scholars from around the country to enhance science for the benefit of all.
2. I earned my Ph.D. in immunology from the University of Toronto.
3. I supervise a lab dedicated to immunological research. My research focuses on immune defenses against viruses at the mucosal surfaces, including respiratory viruses; developing vaccines for viruses; and understanding how to contain and control the spread of viruses. My lab is currently researching immune response to the newly emerging severe acute respiratory syndrome coronavirus 2, SARS-CoV-2, causative agent of COVID-19.
4. I also serve on a task force dedicated to COVID-19 response organized by the Yale Institute of Global Health and the Yale School of Public Health. The Task Force provides insight and public planning to the greater community for best practices at containing the spread of COVID-19.
5. I have published approximately 200 papers and book chapters. A full copy of my curriculum vitae is attached as Exhibit A.
6. I am not being compensated for providing my testimony in this case. I have not previously served as an expert witness.
7. In support of this declaration, I have relied on my scientific and specialized knowledge, skill, experience, training, and education. I have also reviewed the following materials:
 - a. Declarations of Fermin Trujillo Lopez, Gilberto Pablo Perez, Jose Mejia Rosas, Juan Aguilar Castaneda, Livia Pinheiro, Maynor Oxlaj Siguantay, Pravindar Singh, Arias Marroquin, Asif Massom Qazi, and Aylaliyah Burru;
 - b. Defendants' Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Supplemental Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Second Supplemental Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Third Supplemental Responses to Plaintiffs' Initial Set of Interrogatories.

A. COVID-19 Is Caused by A Novel, Highly Contagious Virus.

8. COVID-19 is caused by SARS-CoV-2, a novel virus that is perhaps two or three times as contagious as the flu. There is no vaccine for COVID-19.

9. The virus causing COVID-19, like other respiratory viruses, is primarily spread by contact with droplets containing viral particles. An infected person expels contaminated droplets by sneezing, coughing, breathing, talking, or eating. These droplets travel through the air in the form of larger droplets ($> 5\text{-}10\text{ }\mu\text{m}^1$ in diameter). Another person comes in contact with the droplets either directly, by inhaling infected droplets, or indirectly, by contact with their own mucous membranes, primarily from touching an infected surface and then touching their face.

10. Separate from respiratory droplet transmission, viruses can be transmitted by airborne small droplet nuclei ($\leq 5\text{ }\mu\text{m}$ in diameter, and sometimes referred to as aerosols). Aerosols are so small that their buoyancy overcomes gravity, allowing the droplet nuclei to stay suspended in the air and travel relatively long distances. This is often referred to as airborne transmission.

11. There is an ongoing scientific debate about whether the virus causing COVID-19 is also subject to airborne transmission. While the World Health Organization has not yet recognized airborne transmission in non-medical settings,² my interpretation of the data is that COVID-19 can be spread through airborne transmission. I reach that conclusion for several reasons. First, studies of air samples in and outside of hospital rooms of COVID-19 patients revealed evidence of viral contamination in the air samples, toilet facilities, and common surfaces.^{3 4} This indicates that the virus can be aerosolized. Second, studies show that the virus can remain in the air for hours, and up to days on certain surfaces, demonstrating a long half-life and suggesting airborne viability.⁵ Third, mass infection studies suggest airborne spread. In a March cluster study, 52 of 60 attendees at a weekly 2.5-hour choir practice contracted COVID-19; only one member was symptomatic at the practice. Members sat in chairs 6-10 inches apart in a small, indoor gymnasium. Because only one member was symptomatic and aerosol emission during speech is correlated to the loudness of vocalization, COVID-19 was likely transmitted, in part, by aerosol particles.⁶ Airborne spread is concerning because smaller droplets can travel longer distances and easily reach the lower respiratory tract.⁷

12. COVID-19 is a highly contagious disease, in part, because the minimal infectious dose -- the number of particles necessary to initiate an infection -- is suspected to be low. Infectious

¹ A μm is a micrometer, often referred to as a micron. A micron is one millionth of a meter, or about 0.000039 inch. By comparison, the diameter of a human hair is about 20-40 microns.

² 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>.

³ Santarpia, Joshua L, et al., Transmission Potential of SARS-CoV-2 in Viral Shedding Observed at the University of Nebraska Medical Center, Mar. 26, 2020, <https://www.medrxiv.org/content/10.1101/2020.03.23.20039446v2>.

⁴ Guo, Z.D. et al., Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020, *Emerg Infect Dis*, Vol. 26, Number 7 (July 2020) <https://doi.org/10.3201/eid2607.200885>

⁵ Doremalen N van Bushmaker T, Morris DH, et al. Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. *N Engl J Med* 2020. doi:10.1056/NEJMc2004973

⁶ Hammer, L. et al, High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice – Skagit County, Washington, March 2020 (May 12, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm>

⁷ Atkinson, J. Chartier Y., Pessoa-Silva C.L. et al., Natural Ventilation for Infection Control in Health-Care Settings, Geneva: World Health Organization (2009), <https://www.ncbi.nlm.nih.gov/books/NBK143281/>.

dose studies for previous coronaviruses, MERS and SARS,^{8 9} suggest that as few as 10,000 viral particles could lead to infection. But the higher effective reproduction number (or “R number”) of COVID-19 (~2.5)—the average number of people to whom one infected person will pass the virus—leads immunologists to believe that the minimal infectious dose of COVID-19 is lower than MERS (0.3-0.8), and could be as few as 1,000 viral particles.

13. That infectious dose is low. For reference, a single droplet can contain many thousands of viral particles. A single cough can release 3,000 droplets, a single sneeze can emit 30,000 droplets,¹⁰ and a single breath can release 50-5,000 droplets.¹¹ If a person is infected, the droplets in a single cough or sneeze can contain as many as 200,000,000 virus particles, which are dispersed in the area around the carrier.

14. The likelihood of infection is correlated to exposure dose multiplied by exposure time. Because of the minimal infectious dose, brief exposure to a carrier can result in infection. And, the longer a person is exposed to a carrier, the more likely they are to contract COVID-19.

15. Viral load is the amount of virus present in a volume of fluid. Viral load can be measured by the amount of virus detected in nasal swabs. The higher the viral load, the more likely a carrier is to shed viral particles, making them more likely to infect others. Moreover, although COVID-19 research remains in its early stages, there is an association between viral load per exposure and severe clinical outcomes.¹² Early data suggesting an association between viral load and severe clinical outcomes is not surprising considering that similar coronaviruses, SARS and MERS, showed similar associations between increased viral load exposure and intensive care or death.^{13 14} The science stands for a basic proposition: the more viral particles a person becomes exposed to, the more likely they are to be successfully infected and to have an adverse outcome.

16. Infectious dose and viral load are similar but distinct concepts. Infectious dose can be thought of as the “spark”: how much of the virus is needed to start an infection. Viral load can be thought of as the “fire”: how brightly the virus is burning in an individual once infected.

⁸ De Wit, E.; Rasmussen, A., et al., Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Causes Transient Lower Respiratory Tract Infection in Rhesus Macaques, *PNAS*, (2013) <https://www.pnas.org/content/pnas/110/41/16598.full.pdf>

⁹ Watanabe, T., Bartand T., et al., Development of a Dose-Response Model for SARS Coronavirus, *Risk Analysis*, Vol. 30, No. 7 (2010), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1539-6924.2010.01427.x>

¹⁰ Atkinson, J. Chartier Y., Pessoa-Silva C.L. et al., Natural Ventilation for Infection Control in Health-Care Settings, *Geneva: World Health Organization* (2009), <https://www.ncbi.nlm.nih.gov/books/NBK143281/>.

¹¹ Tang, J.W., Li, Y., Eames, I., Factors involved in the aerosol transmission of infection and control of ventilation in healthcare premises, *Journal of Hospital Infection*, (2006).

¹² Liu, Y., Yan, L-M, et al., Viral dynamics in mild and severe cases of COVID-19, *Lancet*, (Mar. 19, 2020), [https://doi.org/10.1016/S1473-3099\(20\)30232-2](https://doi.org/10.1016/S1473-3099(20)30232-2)

¹³ Chu, C.M., Poon L.L.M., et al., Initial viral load and the outcomes of SARS, *CMAJ*, (2004), <https://www.cmaj.ca/content/171/11/1349>

¹⁴ Feikin, D., Alraddadi B. et al., Association of Higher MERS-CoV Virus Load with Severe Disease and Death, Saudi Arabia, 2014, *Emerging Infectious Disease*, 2015 Nov; 21(11): 2029-2035; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4622256/>

17. Presymptomatic or asymptomatic individuals can be infected and carry the virus. In fact, recent studies have found that viral shedding peaked at the presymptomatic stage of infection, or at the time of symptom onset, increasing the likelihood of presymptomatic transmission in the absence of significant population-level testing.¹⁵ Thus, the only way to know you have a coronavirus is to be tested. The lack of adequate testing and high rate of asymptomatic transmission has contributed to the high rate of spread. Many asymptomatic carriers do not know they have the virus even after they have passed it on to others.

18. COVID-19 has an incubation period of up to 14 days and perhaps longer. A recent study found that detectable virus persisted in patients for a median of 20 days for survivors, and that it was sustained until death for non-survivors.¹⁶ This means that the period in which an infected person can infect others is quite long and broad.

19. These factors—low infectious dose, long half-life, weeks-long incubation and infection periods, asymptomatic carriers with high viral loads, and droplet transmission with the possibility of airborne transmission as well—all combine to make COVID-19 highly contagious.

20. Epidemiologists strive to trace outbreaks to origin points. Researchers use the term “super-spreader event” to refer to origin points that led to clusters of infection—multiple infections stemming from the same origin point. Super-spreader events commonly share environmental factors, including densely populated events, closed or indoor spaces, and prolonged exposure periods.¹⁷ Super-spreader events have occurred at funerals, parties, choir sessions, indoor sporting events, and meatpacking plants.

B. Social Distancing Protects Against Droplet Transmission.

21. The CDC recommends social distancing. This includes avoiding large gatherings, avoiding unnecessary interaction outside of a family unit, and maintaining a distance of at least six feet from others.

22. The six-foot social distancing framework is based in part on average distances large liquid droplets travel after being emitted. Many cite to a 1942 study as the genesis of the 1-2 meter (3-6 feet) rule, which used high-speed photographs to track the distance of large droplet spread (it did not track smaller nuclei transmissions).^{18 19} Notably, however, pathogen-bearing

¹⁵ He, X.m Lau, E.H.Y., et al, Temporal dynamics in viral shedding and transmissibility of COVID-19. *Nature Medicine* 26, 672–675 (Apr. 15, 2020). <https://doi.org/10.1038/s41591-020-0869-5>

¹⁶ Zhou, F., Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study, *Lancet* Vol. 395, Issue 10229, 1054-1062 (Mar. 28-Apr. 3 2020), <https://www.sciencedirect.com/science/article/pii/S0140673620305663>

¹⁷ Frieden T.R., Lee C.T., Identifying and interrupting superspreading events—implications for control of severe acute respiratory syndrome coronavirus 2, *Emerging Infectious Diseases*, Vol. 26, Number 6 2020 Jun (Mar. 18, 2020) <https://doi.org/10.3201/eid2606.200495>

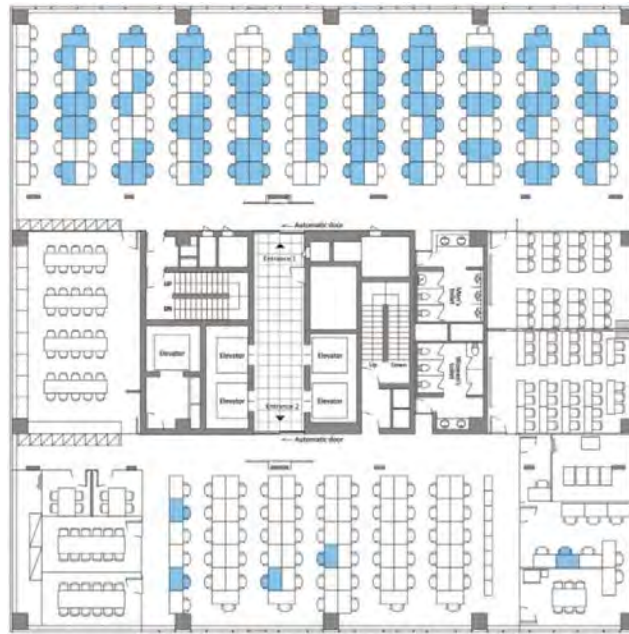
¹⁸ Jennison MW. Atomizing of mouth and nose secretions into the air as revealed by high-speed photography. *Aerobiology*. 17th ed. American Assn. for the Advancement of Science; 1942. p. 106–128

¹⁹ Bahl P, Doolan C, de Silva C, Chughtai AA, Bourouiba L, MacIntyre CR. Airborne or droplet precautions for health workers treating COVID-19? *J Infect Dis*. 2020; (Apr. 16, 2020) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7184471/>

droplets may travel as far as 27 feet.²⁰ Accordingly, while not a perfect solution, six-foot social distancing is safer than no social distancing because it provides a significant degree of protection of individuals against droplet transmission.

23. Moreover, the six-foot social distancing standard is not a complete solution for congregate settings where viral exposure is likely to occur over a sustained period of time. The longer a person is exposed to the same dose, the higher the likelihood of infection. This is why the likelihood of infection from exposure at a given distance during a trip to the supermarket or on a sidewalk is fundamentally different than the likelihood of infection from exposure at the same distance during prolonged, congregate detention.

24. For example, a study from South Korea demonstrates that prolonged exposure to COVID-19 in an enclosed space dramatically increases the likelihood of infection. At a call center, a single infected employee came to work on the eleventh floor of an office building. The office floor had 216 employees—slightly higher than the population level currently at Mesa Verde. In just one week, 94 of the 216 employees on the eleventh floor (43.5%) became infected. The figure below demonstrates the seating chart on the eleventh floor for employees; blue spaces indicate those who became infected.²¹



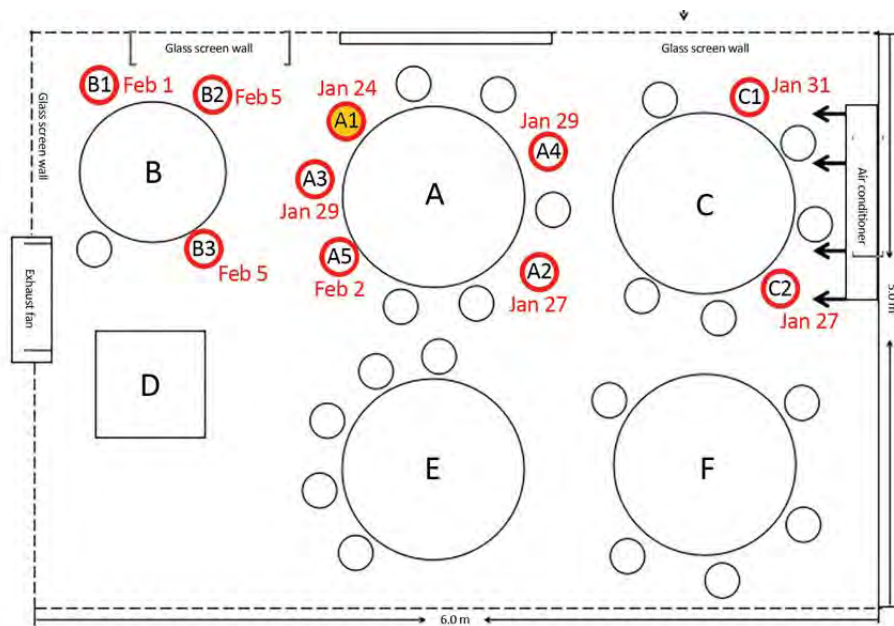
25. As the figure above indicates, widespread infection occurred in one week. Many employees were infected even though they worked on opposite sides of the office than the original carrier. This study illustrates that being in an enclosed space, sharing the same air, and spending prolonged periods around carriers increases the chances of exposure and infection. The

²⁰ Bouroubia, L., Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19; *Journal of the American Medical Association* (Mar. 26, 2020), <https://jamanetwork.com/journals/jama/fullarticle/2763852>.

²¹ Park SY, Kim YM, et al., Coronavirus Disease Outbreak in Call Center, South Korea, *Emerg Infect Dis.* 2020 Aug. <https://doi.org/10.3201/eid2608.201274> (Apr. 23, 2020).

risk of infection is even more heightened in the context of a detention center because detainees spend more time together than employees at an office.

26. Another recent study demonstrates the risk posed to those immediately adjacent to an asymptomatic carrier for a relatively brief amount of time. Epidemiologists in Wuhan, China studied the impact of one asymptomatic carrier—from talking, breathing, and eating—on adjacent diners at a restaurant over the course of a 1-1.5 hour meal. At a ten-person dinner, approximately 50% of the people at the infected person's table became sick over the next seven days. Seventy-five percent of the people at the adjacent table downwind, three meters (approximately 10 feet) from the asymptomatic carrier's table, became infected. Two of the seven people at the adjacent table upwind, three meters (approximately 10 feet) from the asymptomatic carrier's table, became infected.²²



27. The above example demonstrates the risks posed to those adjacent to asymptomatic carriers. In a dorm setting, the likelihood of transmission is even higher because the carrier will expel many more viral particles for a duration much greater than 1.5 hours.

28. Six-foot social distancing provides some protection against droplet transmission. While more must be done to protect individuals, including depopulation, further spacing (particularly for prolonged exposure such as while in bed), and protective barriers, six-foot distancing is a basic first step that makes detainees relatively safer from liquid droplet transmission.

²² Lu J, Gu J, Li K, Xu C, Su W, Lai Z, et al. COVID-19 outbreak associated with air conditioning in restaurant, Guangzhou, China, 2020. *Emerg Infect Dis.* (2020); <https://doi.org/10.3201/eid2607.200764>; https://wwwnc.cdc.gov/eid/article/26/7/20-0764_article

C. The Current Conditions at Mesa Verde and Yuba County Jail Expose Detainees and Staff to a Significant Risk of Contracting COVID-19.

29. From what I have reviewed regarding the conditions for immigration detainees at Yuba County Jail and Mesa Verde, there is an extraordinarily high risk of infectious spread of COVID-19 at these two facilities.

30. Mesa Verde has four dorms with 50 bunk beds in each dorm in close proximity to one another. Detainees report spending upwards of 18 hours each day in their bunks; they sleep and socialize in their dorm rooms.²³ The top bunk is 49 inches above the bottom bunk, or slightly more than four feet. The median distance between each bunk is 38 inches, slightly more than three feet.

31. I understand that ICE now staggers detainees in Mesa Verde in some dorms to sleep alternating between bottom and top bunks on neighboring bunk beds so that no two individuals sleep in the same bunk bed. Unfortunately, staggering detainees in this way does little to reduce the spread of infection. Pathogens will still reach those in adjacent beds and larger droplets are pulled to the ground by gravity, whether or not there is airborne transmission.²⁴ This means that, even with staggering, a person in a top bunk is likely to infect people in neighboring beds regardless of whether an individual is in the upper or lower bunk in the next bed.

32. At Yuba County Jail, detainees are housed in various congregate living formats. Most sleep in beds 2-4 feet apart. Moreover, detainees report spending significant amounts of time in their dorm pods (the vast majority of the day, some estimating spending approximately 18 hours per day), a few feet apart from one another.²⁵

33. The combination of a highly contagious disease and the risks of prolonged exposure create a very high likelihood of infection with all the inherent risks for the individual infected as well as the public health. Nearly every so-called “super spreader” event shares common environmental characteristics of Mesa Verde and Yuba County Jail: many people congregating indoors in close proximity for prolonged periods of time.

34. In my opinion, it is fundamentally unsafe to house individuals in the current conditions at these two facilities. Because of the close proximity between beds, one infection will trigger a domino effect. Infection will spread at faster rates than the call center example or restaurant example because the exposure period is longer, and multiple carriers will increase the viral dose being circulated in the facilities. Detaining human beings in the current conditions at these two detention facilities during this pandemic all but guarantees mass infection.

²³ Declaration of Asif Massom Qazi at ¶ 6.

²⁴ Atkinson et al., Natural Ventilation for Infection Control in Health-Care Settings, *Geneva: World Health Organization* (2009), <https://www.ncbi.nlm.nih.gov/books/NBK143281/>.

²⁵ Pravindar Singh Declaration, ¶ 7.

D. Increased Viral Loads in the Current Conditions Will Increase the Severity of an Outbreak.

35. Congregate settings are dangerous in part because they lead to increased viral load exposure. Detainees continuously inhale viral particles from those nearby. In most infectious diseases, the amount of virus in an infected person affects how likely someone is to infect others, and how sick they become from that infection. Due to the nascency of COVID-19, the relationship between viral load and patient outcomes is not fully known, but early data suggests patients with a greater viral load are more likely to have severe outcomes and more likely to be infected for a longer duration. These data are consistent with other coronaviruses and infectious diseases in general.

36. In a recent study, researchers measured the viral load of 76 patients admitted to a hospital in Nanchang, China. Thirty of the tested patients had severe COVID-19 cases; the other 46 had mild cases. Severe cases were identified as those with respiratory failure, requiring mechanical ventilation, septic shock, or organ failure, among other criteria. The mean viral load of severe cases was around 60 times higher than that of mild cases, suggesting that higher viral loads are associated with severe clinical outcomes.²⁶ The study also found that severe cases were sicker for longer; a cross sample of ten severe cases all tested positive 21 days post onset. By comparison, a cross sample of 21 mild cases found that 90% of the cross sample cleared the virus within 10 days post symptom onset. This suggests that not only do those with a greater viral load experience worse outcomes, but they remain sicker longer, meaning they can expose others to the virus for a longer duration of time.

37. The study referenced above is consistent with previous research on other coronaviruses. A 2004 study on severe acute respiratory syndrome (SARS) found evidence that higher initial viral load is independently associated with worse prognosis in SARS.²⁷ A 2014 study on Middle East respiratory syndrome coronavirus (MERS-CoV) found an association between higher viral load of MERS-CoV and worse clinical outcomes, including death and admission to the ICU.²⁸ Based on early COVID-19 studies and studies of previous coronaviruses, there is strong reason to believe that COVID-19 behaves similarly to these other coronaviruses with respect to viral load.

38. The relationship between greater viral load and severe clinical outcomes is seen anecdotally in the number of otherwise healthy first-line health care responders who have become critically ill or died from prolonged COVID-19 exposure from treating sick patients. The same phenomenon is seen in other contagious diseases. For example, viral load in children infected with the 2009 pandemic influenza virus correlated with disease severity and prolonged

²⁶ Liu, Y, Yan, L-M, et al., Viral dynamics in mild and severe cases of COVID-19, *Lancet Infectious Disease*, (Mar. 19, 2020), [https://doi.org/10.1016/S1473-3099\(20\)30232-2](https://doi.org/10.1016/S1473-3099(20)30232-2)

²⁷ Chu, C.M., Poon L.L.M., et al., Initial viral load and the outcomes of SARS, *CMAJ*, (2004), <https://www.cmaj.ca/content/171/11/1349>

²⁸ Feikin, D., Alraddadi B. et al., Association of Higher MERS-CoV Virus Load with Severe Disease and Death, Saudi Arabia, 2014, *Emerging Infectious Disease*, 2015 Nov; 21(11): 2029-2035; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4622256/>

viral shedding.²⁹ Higher viral load also correlated with worse disease severity for children infected with respiratory syncytial virus.³⁰

39. Increased viral load also leads to increased viral shedding. Those infected with more virus shed more virus, releasing pathogens that can infect those near the carrier. Because presymptomatic carriers have been found to have high viral shedding,³¹ there is a significant risk of a carrier with a high viral load infecting many around him or her.

E. Common Areas at Yuba County Jail and Mesa Verde are Prone to Overcrowding and Poor Sanitation Practices

40. The fact declarations submitted by detainees depict a dangerous environment where people live in close proximity, use common bathrooms with open air between stalls, and stand in lines throughout the day. The many shared common spaces and amenities create a high likelihood of mass infection.

41. In addition to social distancing, increased vigilant cleaning and personal hygiene is vital to slowing the spread of the COVID-19. Because the virus remains viable on certain surfaces for more than a day,³² shared common spaces such as doorknobs, bathrooms, sinks, toilets, showers, and eating halls pose a significant risk of transmission even if people use these facilities individually.³³ If a person touches an infected surface, and then touches his face, he will expose his mucous membranes to the virus. Moreover, because COVID-infected aerosol has a half-life of over an hour, virus-infected air will circulate around heavily populated shared spaces.

42. To reduce the risk of further transmission, any shared space needs to be cleaned with FDA-approved cleaning solutions after each use.

43. I understand that cloth masks have been made available. Surgical or cotton masks do not adequately protect against the virus because they do not protect against particles measuring less than five microns.³⁴ Accordingly, the masks provided do not sufficiently protect against the risk of mass infection.

²⁹ Li, C.C. et al., Correlation of Pandemic (H1N1) 2009 Viral Load with Disease Severity and Prolonged Viral Shedding in Children, *Emerg Infectious Dis.* Vol. 16, Number 8 (Aug 2010), https://wwwnc.cdc.gov/eid/article/16/8/09-1918_article

³⁰ Uusitupa, E., Association of Viral Load With Disease Severity in Outpatient Children with Respiratory Virus Infection, *The Journal of Infectious Diseases*, (Feb. 18, 2020), <https://doi.org/10.1093/infdis/jiaa076>

³¹ He, X.m Lau, E.H.Y., et al, Temporal dynamics in viral shedding and transmissibility of COVID-19. *Nature Medicine* 26, 672–675 (Apr. 15, 2020). <https://doi.org/10.1038/s41591-020-0869-5>

³² Aerosol and Surface Stability of SARS-COV-2 as Compared with SARS-CoV-1. *N. Engl. J. Med.* (Apr. 16, 2020) https://www.nejm.org/doi/full/10.1056/NEJMc2004973?query=featured_home

³³ Guo, Z.D. et al., Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020, *Emerg Infect Dis*, Vol. 26, Number 7 (July 2020) <https://doi.org/10.3201/eid2607.200885>

³⁴ Bae. S. et al., Effectiveness of Surgical and Cotton Masks in Blocking SARS-CoV-2: A Controlled Comparison in 4 Patients, *Annals of Internal Medicine*, (Apr. 6, 2020), <https://www.acpjournals.org/doi/10.7326/M20-1342>.

F. Mass Testing, Quarantining, and Contact Tracing is Needed.

44. I understand that as of April 24, 2020, only two detainees at Yuba County Jail and Mesa Verde had been tested for COVID-19. Without a consistent, reliable testing, quarantining, and contact tracing program (determining who infected people have previously come in contact with and ensuring their appropriate follow-up), it is impossible to determine whether infections have already started at either of these two facilities.

45. A robust testing program needs to be implemented immediately. All newcomer detainees should be quarantined until the test result comes back negative or for fourteen days, whichever is first, before being allowed to enter the facility.

46. To contain the spread of the virus, all possible efforts must be made to reduce the number of viral particles circulating, or at risk of circulation, in Yuba County Jail and Mesa Verde Detention Center. The best way to reduce the risk of mass infection is to significantly depopulate the facility: any congregate living environment has inherent risks because of the unavoidable interactions between large numbers of people. The practically inevitable spread of the virus will infect fewer people if there are fewer people living in these congregate environments. Further, only significant depopulation makes any social distancing for those who remain possible. Social distancing of at least six feet for transient interactions helps to protect against droplet transmission, and is a bare minimum first step to make people relatively safer from such a form of transmission. Given the increased viral exposure over prolonged periods in confined areas for sleeping, in addition to the likelihood of airborne transmission, social distancing of greater than six feet is necessary between the beds of detainees to reduce the risk of droplet transmission to detainees in these facilities.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.



Akiko Iwasaki, Ph.D.
Waldemar Von Zedtwitz Professor of Immunobiology; of
Molecular, Cellular and Developmental Biology
Yale School of Medicine
The Anlyan Center
300 Cedar Street, Suite S630
New Haven, CT 06519

April 4, 2020

CURRICULUM VITAE**Akiko Iwasaki**Academic Address

Howard Hughes Medical Institute
 Department of Immunobiology
 Yale University School of Medicine
 300 Cedar Street, TAC S655B
 P.O. Box 208011
 New Haven, Connecticut USA
 06520-8011
 Phone (203) 785-2919
 FAX (203) 785-4972
 e-mail: akiko.iwasaki@yale.edu

Home Address

1533 Alexander Drive
 Guilford
 Connecticut
 06437
 USA
 (203) 689-5034

EDUCATION

- 1998 **Ph.D.** in Immunology, University of Toronto
 Thesis: "Cytotoxic T Lymphocyte Induction by Plasmid DNA Immunization:
 Mechanism and Applications"
 Supervisor: Professor Brian H. Barber, University of Toronto
- 1994 **B.Sc.** Biochemistry Specialist Program, University of Toronto
 Physics Minor Program, University of Toronto

CAREER

- 2018 - present Waldemar Von Zedtwitz Professor of Immunobiology; of Molecular, Cellular and
 Developmental Biology; and of Dermatology, Yale University School of Medicine,
 Investigator, Howard Hughes Medical Institute
- 2016 - 2018 Waldemar Von Zedtwitz Professor of Immunobiology and of Molecular, Cellular and
 Developmental Biology, Yale University School of Medicine, Investigator, Howard
 Hughes Medical Institute
- 2014 - present Investigator, Howard Hughes Medical Institute
- 2011 – 2016 Full Professor with Tenure
 Department of Immunobiology and Department of Molecular, Cellular and
 Developmental Biology
 Yale University School of Medicine
- 2009 – 2011 Associate Professor with Tenure
 Department of Immunobiology and Department of Molecular, Cellular and
 Developmental Biology

Yale University School of Medicine

2006 - 2009 Associate Professor
Department of Immunobiology
Yale University School of Medicine

2004 - 2006 Assistant Professor
Section of Immunobiology
Yale University School of Medicine

2000-2004 Assistant Professor
Department of Epidemiology and Public Health
Yale University School of Medicine

1998-2000 Postdoctoral Fellow
Supervisor Dr. Brian Kelsall
Mucosal Immunity Section,
National Institutes of Allergy and Infectious Diseases, NIH

1993-1998 Ph.D. Research Project
Supervisor: Professor Brian H. Barber
Department of Immunology, University of Toronto

1992-1993 Undergraduate Research Project
Supervisor: Professor Robert H. Painter
Department of Biochemistry

ACADEMIC AWARDS

1990-1993 Faculty Scholar

1991-1993 St. Michael's College Scholarship

1993 Silver Medalist at St. Michael's College

1993-1994 Massey College Fellow

1993-1996 Connaught Scholarship

1996-1998 Ontario Graduate Scholarship

1998 Natural Sciences and Engineering Research Council of Canada Fellowship Awarded

1998-2001 Medical Research Council of Canada Fellowship

2000 The Fellows Award for Research Excellence

2000 Canadian Society for Immunologist Travel Award

2002 Young Investigator Award from Society for Mucosal Immunology.

2000-2003 Burroughs Wellcome Fund Career Award in Biomedical Sciences

2003-2005 Ethel Donaghue Women's Health Program Investigator Award

2003-2005 Wyeth Lederle Young Investigator Award, Infectious Diseases Society of America

2005-2010 Burroughs Wellcome Fund Investigator in Pathogenesis in Infectious Diseases

2011 American Associations of Immunologists (AAI) BD Biosciences Investigator Award

2012 Eli Lilly and Company Research Award, American Society for Microbiology

2013 Master of Arts *Privatum*, Yale University

2014 Appointed, HHMI Investigator

2016 Elected to the Connecticut Academy of Science and Engineering

2017 Winner, Inspiring Yale, Yale University

2018	American Associations of Immunologists (AAI) Thermo Fisher Meritorious Career Award
2018	Charles W. Bohmfalk Teaching Award, Yale School of Medicine
2018	Elected to the Council of the American Associations of Immunologists
2018	Elected to the National Academy of Sciences
2019	Seymour & Vivian Milstein Award for Excellence in Interferon and Cytokine Research
2019	Elected to the National Academy of Medicine
2020	Elected to the American Academy of Microbiology

KEYNOTE AND NAMED LECTURES

2010	The 26th Shipley Symposium Lecture, Harvard Medical School
2011	Keynote speaker, University of Michigan, Immunology Annual Retreat
2011	Keynote speaker, La Jolla Immunology Conference
2013	Keynote speaker, Harvard Immunology Annual Retreat
2014	Sloan-Kettering President's Research Seminar Series
2014	Tyrrell Lectureship in Infection and Immunity at the University of Alberta
2014	R.E. Dyer Lecture, NIH
2015	Keynote speaker, International Herpes Workshop, Boise, Idaho
2015	The 6th Kishimoto Foundation Lecture, Osaka University, Japan
2016	Eberly Lecture, University of Pittsburgh
2016	President's Symposium, American Association of Immunologists meeting, Seattle, Washington
2016	Keynote speaker, British Society for Immunology and the Dutch Society for Immunology joint meeting, Liverpool UK
2017	Weiser Endowed Lecture in Immunology, University of Washington, Seattle, Washington
2017	The 31 st Richard Parker Memorial Lecture, Columbia University, NY, NY
2017	Inaugural Lecture, Evergrande Center for Immunologic Diseases, Boston, Massachusetts
2017	Keynote Pixie Campbell lecture, Colorado Immunology Conference, Vail, CO.
2018	Keynote speaker, Keystone Symposium on Cells vs. Pathogens, Monterey, CA.
2018	Keynote speaker, New England Immunology Conference, Woods Hole, MA
2019	Keynote speaker, EMBO Pathogen Immunity and Signalling conference, Oxford, UK
2019	J.S. and H.R Blumenthal Memorial Lecture, University of Minnesota
2019	Benning Medical Society Lecture, University of Utah
2019	Keynote speaker, American Society for Virologists, University of Minnesota
2019	Philip J. Bassford Memorial Lecture, University of North Carolina at Chapel Hill
2019	Guru, NIH Immunology Interest Group Workshop
2019	56th Charles A. Stuart Memorial Lecture and Brown University
2020	Keynote speaker, NextGen Immunology, Rehovot, Israel
2020	Bertram Marx Lecture University of Alabama at Birmingham

EDITORIAL BOARDS

2008-2012	Associate Editor, <i>Mucosal Immunology</i>
2010-present	Associate Editor, <i>Trends in Immunology</i>
2017-present	Advisory Editorial Board, <i>Journal of Experimental Medicine</i>
2017-2019	Editorial Board, <i>Current Topics in Immunology and Microbiology</i>
2018-present	Board of Reviewing Editors, <i>Science</i>
2020-present	Editorial Advisory Board, <i>Cell Host and Microbe</i>
2020-present	Editorial Advisory Board, <i>Cell</i>

2020-present Editorial Advisory Board, *Trends in Molecular Medicine*

ADVISORY BOARDS

2010-2011 Member, External Advisory Board, Midwest Regional Center of Excellence for Biodefense and Emerging Infectious Diseases Research

2010-2012 Member, Scientific Advisory Board, Program Project Grant Reproductive Immunology, Yale University

2012-2018 Member, joint steering committee, AbbVie-Yale Collaboration in Immunology.

2014-present Scientific Advisory Board, Program in Cellular & Molecular Medicine, Boston Children's Hospital

2015-present Scientific Advisory Board, Burroughs Wellcome Fund, Investigator in Pathogenesis of Infectious Diseases

2016-2017 International Scientific Advisory Board, International Cytokine and Interferon Society

2017-2018 Scientific Advisory Board, Hanna H. Gray Fellowship Program, Howard Hughes Medical Institute

2017-2019 Japan Society for the Promotion of Science International Science Fund Advisory Board - 日本学術振興会 国際科学研究費委員

2018-2019 Scientific Advisory Board, Schmidt Science Fellows Program

2018-present Board of Scientific Advisors, The Jane Coffin Childs Memorial Fund for Medical Research

2018-present Scientific Advisory Board, Gulbenkian Foundation, Portugal

2018-present Scientific Advisory Board, Ragon Institute, Boston MA

2019-present Scientific Advisory Board, training program of the Serrapilheira Institute

SOCIETIES

1998-2004 Canadian Society for Immunologists

2000-present American Association of Immunologists

2003-2005 Infectious Diseases Society of America

2000-present Society for Mucosal Immunology

2000-present American Society for Microbiology

YALE COMMITTEES

Department

2016-present Vice Chair

2016-present Chair of Space Allocation Committee

2016-present Medical Education Committee

2017-2018 Faculty Search Committee

Junior Faculty Mentorship committee for;

Jeff Ishizuka

Andrew Wang

Noah Palm

Carrie Lucas

Ann Haberman

Grace Chen

Craig Wilen

Jon Koff (past)

Medical School

2011-2013 Funds and Fellowship Committee, Member (2011-2012), Chair (2013)
 2016-present Women in Science Initiative Committee
 2018-present Office of Research Integrity Committee
 2018-present K12 ITOP Advisory Committee
 2019-present Brain tumor center advisory board
 2019-present Yale Center for Immuno-oncology (YCIO) advisory board

University

2017-2019 University Science Strategy Committee
 2019 Dean Search Committee Advisory Board
 2019-present OCR Committee

Community Outreach

I am an advocate of women and underrepresented minority scientists. My outreach activities are through direct mentorship (my lab is always more than 50% women), and through outreach via publication and social media including Twitter (@VirusesImmunity). I have over 17K followers.

RESEARCH SUPPORT**ACTIVE**

Howard Hughes Medical Institute (Iwasaki) 05/15/2014 – 05/14/2026

To understand the cellular and molecular mechanisms of innate virus recognition and in elucidating innate signals that lead to the generation of protective immune responses and to apply such understanding to create effective vaccines

2R01EB000487-22A1 (Saltzman & Iwasaki) 09/16/2017 – 06/30/2020

NIH/NIBIB

Cellular and molecular transport in mucus

The major goals of this project are to examine whether vaginally delivered nanoparticles can prevent or treat HSV-2 genital infections.

Meier Corporation Gift (Iwasaki) 10/01/2015-9/30/2020

Role of humidity and temperature on respiratory antiviral immunity

This is a gift from Condair Group AG to the lab. We use this gift to study the impact that humidity and temperature has on respiratory immunity to influenza viruses.

R01AI127429 (Iwasaki) 06/01/2017 - 05/31/2022

NIH NIAID

B cell based protection against recurrent herpes

This grant proposes to examine the mechanism by which protective immunity is mediated by memory T cells and B cells, and apply this finding to generate a novel effective vaccine against HSV-2.

2R01AI054359-14 (Iwasaki) 04/01/15 - 03/31/20

NIH NIAID

Immunity to Genital Herpes Simplex-2

The major goals of this project are to determine the mechanisms by which dendritic cells initiate CD4+

T cell immunity in the vaginal mucosa.

2U19AI089992-06A1 (Hafler) 12/19/16 - 11/30/21
NIH NIAID

Systems Immune Profiling of Divergent Responses to Infection

The goal of this proposal is to identify patterns of gene expression, metabolic or cell function in the human immune system that are "signatures" of a response to influenza vaccination. We will also evaluate how these signatures are altered in older versus young individuals, and in a subset of so-called frail older individuals who are at high risk for death and disability.

Stand Up To Cancer, a division of Entertainment (Santin) 01/01/18 - 12/31/20
Responders and Non-responders to Endometrial Cancers with Mismatch Repair

To use the reagents from the A phase II evaluation of pembrolizumab to predict the responder vs. non-responder phenotypes to PD1 blockade.

R01 NS111242 (Iwasaki/Kaczmarek) 12/01/19 - 11/30/24
NIH

Role of viral infections in potassium channel-related cerebellar ataxia

The goal of these studies is to decipher the mechanism of cerebellar ataxia

CRUIVV - Center for Research on Universal Influenza Virus Vaccines (Krammer) 08/01/2019
07/31/2026

Subcontract from Mt. Sinai School of Medicine

The goal of this U19 project is to develop universal flu vaccines.

Completed Research Support (last three years)

5 R01 AI 064705-07 (Iwasaki) 04/01/2005 - 01/31/2016

NIH/NIAID

Viral Recognition by Plasmacytoid Dendritic Cell

The major goals of this project are to examine the mechanism of type 1 IFN induction by live viruses in pDCs; determine the cellular mechanisms utilized by pDCs for innate recognition of DNA and RNA viruses; and to examine the in vivo role of pDCs in innate and adaptive immunity following mucosal viral infections.

Abbvie Yale Collaboration In Immunobiology (Iwasaki)

04/15/2013 – 04/14/2017

AbbVie Research Study

Role of endogenous retroviruses in lupus pathogenesis

The goal of the proposed project is to understand the disease pathogenesis of SLE and possibly develop a new strategy to diagnose, prevent and/or treat SLE in humans.

1R56AI125504-01 (Saltzman & Iwasaki)

07/20/2016 – 06/30/2017

NIH/NIAID

Vaginally-delivered Nanoparticles for Prevention and Treatment of HSV-2

The major goals of this project are to examine whether vaginally delivered nanoparticles can prevent or treat HSV-2 genital infections.

Abbvie Yale Collaboration In Immunobiology (Iwasaki & Medzhitov)

04/15/2013 – 04/14/2018

Identification and targeting of Tfh-inducing dendritic cells

The goal of the proposed project is to understand the disease pathogenesis of SLE and possibly develop a new strategy to diagnose, prevent and/or treat SLE in humans.

1R21AI131284-01 (Iwasaki)

1/06/2017 – 12/31/2018

NIH/NIAID

Innate antiviral defense against Vaginal transmission of ZIKA virus

This project proposes to examine the mechanism by which the innate antiviral pathways control ZIKV transmission and replication in the female reproductive tract, and to understand the maternal vs. fetal intrinsic defense mechanisms that control ZIKV during pregnancy.

2R42AI120269-02

(Bilsel)

07/01/2017 - 06/30/2019

NIH NIAID

Phase II: Restimulating memory T cell responses in elderly by a novel, live influenza vaccine

In this proposal we will test the hypothesis that engaging non-inflammasome dependent innate pathways by M2SR virus results in robust restimulation of memory CD4 and CD8 T cells in older humans without causing pathological inflammation.

Yale Cancer Center Innovation Award (Iwasaki)

11/15/18

-

11/14/19

Exploring the Innate Mechanisms Underlying Cancer Immune Surveillance

We will identify the innate immune sensors involved in tumor recognition, and the key antigen presenting cell types that link this innate recognition to promote anti-tumor T cell responses.

PUBLICATIONS

- 1) **Iwasaki A**, Stiernholm, NBJ, Chan AK, Berinstein NL and Barber BH. Enhanced CTL responses mediated by plasmid DNA immunogens encoding co-stimulatory molecules and cytokines. *Journal of Immunology*, 1997 May 15;158(10):4591-601.
- 2) Torres CA, **Iwasaki A**, Barber BH and Robinson HL. Differential dependence on target site tissue for gene gun and intramuscular DNA immunizations. *Journal of Immunology*, 1997 May 15;158(10):4529-32.
- 3) **Iwasaki A**, Torres CAT, Ohashi PS, Robinson HL and Barber BH. The dominant role of bone marrow-derived cells in CTL induction following plasmid DNA immunization at different sites. *Journal of Immunology*, 1997 Jul 1;159(1):11-4.
- 4) **Iwasaki A** and Barber BH. Induction by DNA immunization of a protective anti-tumour cytotoxic T-lymphocyte response against a minimal epitope-expressing tumour. *Cancer Immunology Immunotherapy* 1998 Jan;45(5):273-9.
- 5) Porgador A, Irvine KR, **Iwasaki A**, Barber BH, Restifo NP and Germain RN. Predominant role for directly transfected dendritic cells in antigen presentation to CD8⁺ T cells after gene gun immunization. *Journal of Experimental Medicine* 1998 Sep 21;188(6):1075-82.. PMID: PMC2212529.
- 6) **Iwasaki A**, Dela Cruz CS, Young AR and Barber BH. Epitope-specific cytotoxic T lymphocyte induction by minigene DNA immunization. *Vaccine*, 1999 Apr 9;17(15-16):2081-8.

- 7) **Iwasaki A** and Kelsall BL. Mucosal immunity and inflammation I. Mucosal dendritic cells: their specialized role in initiating T cell responses. *American Journal of Physiology*, 1999 May;276(5 Pt 1):G1074-8.
- 8) **Iwasaki A** and Kelsall BL. Freshly isolated Peyer's patch, but not spleen dendritic cells produce IL-10 and induce the differentiation of T Helper Type-2 Cells. *Journal of Experimental Medicine*, 1999 Jul 19;190(2):229-39. PMCID: PMC2195574.
- 9) **Iwasaki A** and Kelsall BL. Localization of distinct Peyer's patch dendritic cell subsets and their recruitment by chemokines macrophage inflammatory protein (MIP)-3alpha, MIP-3beta, and secondary lymphoid organ chemokine. *Journal of Experimental Medicine*, 2000 Apr 17;191(8):1381-94.
- 10) He J, Gurunathan S, **Iwasaki A**, Ash-Shaheed B and Kelsall BL. Primary role for Gi-protein signaling in the regulation of interleukin-12 production and the induction of T helper cell type 1 responses. *Journal of Experimental Medicine* 2000 May 1;191(9):1605-10. PMCID: PMC2213427.
- 11) Gurunathan S, Stobie L, Prussin C, Sacks DL, Glaichenhaus N, **Iwasaki A**, Fowell DJ, Locksley RM, Chang JT, Wu CY and Seder RA. Requirements for the maintenance of Th1 immunity in vivo following DNA vaccination: a potential immunoregulatory role for CD8+ T cells. *Journal of Immunology*, 2000 Jul 15;165(2):915-24.
- 12) **Iwasaki A** and Kelsall BL. Unique functions of CD11b⁺, CD8a⁺ and double-negative Peyer's patch dendritic cells. *Journal of Immunology*, 2001 Apr 15;166(8):4884-90.
- 13) Jameson B, Baribaud F, Pöhlmann S, Ghavimi D, Mortari F, Doms RW and **Iwasaki A**. Expression of DC-SIGN dendritic cells of intestinal and genital mucosae in human and rhesus macaques. *Journal of Virology*, 2002 Feb;76(4):1866-75. PMCID: PMC135921.
- 14) Park M, Amichay D, Love P, Wick E, Grinberg A, Rabin R, Gebeyehu S, **Iwasaki A**, Westpal H, DeMartino J, Elkins K and Farber J. Targeted disruption of the MIG gene reveals a role for MIG in antibody production. *Journal of Immunology* 2002 Aug 1;169:1433-43, 2002.
- 15) **Iwasaki A**, Welker R, Müller S, Nomoto A and Wimmer E. Immunofluorescence Analysis of Poliovirus Receptor Expression in the Peyer's Patches of Humans, Primates and *CD155* Transgenic Mice: Implications for poliovirus infection. *Journal of Infectious Diseases* 2002 Sep 1;186(5):585-92.
- 16) Zhao X, Deak E, Soderberg K, Linehan M, Spezzano D, Jia Zhu, Knipe DM. and **Iwasaki A**. Vaginal submucosal dendritic cells, but not Langerhans cells, induce protective Th1 responses to herpes simplex virus-2. *Journal of Experimental Medicine* 2003 Jan 20;197(2):153-62. PMCID: PMC2193810.
- 17) **Iwasaki A**. Commentary: The importance of CD11b⁺ dendritic cells in CD4⁺ T cell activation in vivo: with help from interleukin 1. *Journal of Experimental Medicine*, 2003 Jul 21;198(2):185-90. PMCID: PMC2194080.
- 18) Lund J, Sato A, Akira S, Medzhitov R and **Iwasaki A**. Toll-like receptor 9-mediated recognition of herpes simplex virus-2 by plasmacytoid dendritic cells. *Journal of Experimental Medicine* 2003 Aug 4;198(3):513-20. PMCID: PMC2194085.

- 19) Zhao X, Sato A, Dela Cruz CS, Linehan M, Luegering A, Kucharzik K, Shirakawa AK, Marquez G, Farber JM, Williams I and **Iwasaki A**. CCL9 is secreted by the follicle-associated epithelium and recruits dome region Peyer's patch CD11b⁺ dendritic cells¹. *Journal of Immunology* 2003 Sep 15;171(6):2797-803.
- 20) Sato A, Hashiguchi M, Toda E, **Iwasaki A**, Hachimura S and Kaminogawa S. CD11b⁺ Peyer's patch dendritic cells secrete IL-6 and induce IgA secretion from naïve B cells. *Journal of Immunology* 2003 Oct 1;171(7):3684-90.
- 21) **Iwasaki A**. Invited Review: The role of dendritic cells in immune responses against vaginal infection by the herpes simplex virus type 2. *Microbes and Infection*, 2003 Nov;5(13):1221-30.
- 22) Linehan MM, Richman S, Krummenacher C, Eisenberg R, Cohen G and **Iwasaki A**. In vivo role of Entry of herpes simplex virus type 1 (HSV-1) and HSV-2 through vaginal mucosa. *Journal of Virology* 2004 Mar;78(5):2530-6. PMCID: PMC369262.
- 23) Lund JM, Alexopoulou L, Sato A, Karow M, Adams NC, Gale NW, **Iwasaki A**,*and Flavell RA. Recognition of single-stranded RNA viruses by Toll like receptor 7. *Proc. Natl. Acad. Sci.* 2004 Apr 13;101(15):5598-603. PMCID: PMC397437.
- 24) Soderberg KA, Linehan MM, Ruddle NH, **Iwasaki A**. MAdCAM-1 Expressing sacral lymph node in the lymphotoxin β -deficient mouse provides a site for immune generation following vaginal herpes simplex virus-2 infection. *Journal of Immunology*, 2004 Aug 1;173(3):1908-13.
- 25) **Iwasaki A** and Medzhitov R. Toll-like receptor control of the adaptive immune responses. *Nature Immunology*, 2004 Oct;5(10):987-95.
- 26) Sato A and **Iwasaki A**. Induction of antiviral immunity requires Toll-like receptor signaling in both stromal and dendritic cell compartments. *Proc. Natl. Acad. Sci.* 2004 Nov 16;101(46):16274-9. PMCID: PMC528964.
- 27) Fleeton M, Contractor N, Leon F, He J, Wetzel D, Dermody T, **Iwasaki A** and Kelsall B. Involvement of dendritic cell subsets in the induction of oral tolerance and immunity. *Ann N Y Acad Sci.* 2004 Dec;1029:60-5.
- 28) Sato A and **Iwasaki A**. Peyer's patch dendritic cells as regulators of mucosal adaptive immunity. *Cell. Mol. Life Sci.* 2005 Jun;62(12):1333-8.
- 29) Soderberg KA, Payne GW, Sato A, Medzhitov R, Segal SS and **Iwasaki A**. Innate control of adaptive immunity via remodeling of lymph node feed arteriole. *Proc Natl Acad Sci.*, 2005 Nov 8;102(45):16315-20. PMCID: PMC1283434.
- 30) Colonna M, Pulendran B and **Iwasaki A**. Dendritic cells at the host-pathogen interface. *Nature Immunology*, 2006 Feb;7(2):117-20.
- 31) Shen H and **Iwasaki A**. A crucial role for plasmacytoid dendritic cells in antiviral protection by CpG ODN-based vaginal microbicide. *Journal of Clinical Investigation* 2006 Aug;116(8):2237-43. PMCID: PMC1518794.
- 32) Sato A, Linehan MM and **Iwasaki A**. Dual recognition of herpes simplex viruses by TLR2 and TLR9 in dendritic cells. *Proc. Natl. Acad. Sci.* 2006 Nov 14;103(46):17343-8. PMCID: PMC1859932.

- 33) Lund JM, Linehan MM, Iijima N and **Iwasaki A**. Cutting Edge: Plasmacytoid dendritic cells provide innate immune protection against mucosal viral infection in situ. *Journal of Immunology*, 2006 Dec 1;177(11):7510-4.
- 34) Lee HK, Lund JM, Ramanathan B, Mizushima N and **Iwasaki A**. Autophagy-dependent viral recognition by plasmacytoid dendritic cells. *Science*, 2007 Mar 9;315(5817):1398-401, PMID: 17272685.
- 35) Lee HK and **Iwasaki A**. Innate control of adaptive immunity: dendritic cells and beyond. *Semin Immunol.* 2007 Feb;19(1):48-55.
- 36) **Iwasaki A**. Division of labor by dendritic cells. *Cell* 2007 Feb 9;128(3):435-6.
- 37) **Iwasaki A**. Mucosal dendritic cells. *Annual Review of Immunology*, 2007;25:381-418.
- 38) **Iwasaki A**. Role of autophagy in innate viral recognition. *Autophagy* 2007 Jul-Aug;3(4):354-6.
- 39) Iijima N, Linehan MM, Saeland S and **Iwasaki, A**. Vaginal epithelial dendritic cells renew from bone marrow precursors. *Proc. Natl. Acad. Sci.* 2007 Nov 27;104(48):19061-6. PMCID: PMC2141908.
- 40) Miller BC, Zhao Z, Stephenson LM, Cadwell K, Pua HH, Lee HK, Mizushima NN, **Iwasaki A**, He YW, Swat W, Virgin HW. The autophagy gene ATG5 plays an essential role in B lymphocyte development. *Autophagy*, 2008 Apr;4(3):309-14.
- 41) Klionsky DJ et al. Guidelines for the use and interpretation of assays for monitoring autophagy in higher eukaryotes. *Autophagy*. 2008 Feb;4(2):151-75. PMCID: PMC2654259.
- 42) Thompson JM, **Iwasaki A**. Toll-like receptors regulation of viral infection and disease. *Adv Drug Deliv Rev.* 2008 Apr 29;60(7):786-94. PMCID: PMC2410298.
- 43) Lee HK, **Iwasaki A**. Autophagy and antiviral immunity. *Curr Opin Immunol.* 2008 Feb;20(1):23-9. PMCID: PMC2271118
- 44) Yap GS, **Iwasaki A**. Securing mucosal borders--migrant monocytes to the rescue. *Cell Host Microbe*. 2008 Sep 11;4(3):192-4.
- 45) Thompson, JM, Nicholson MG, Whitmore AC, Zamora M, West A, **Iwasaki A**, Staats HF, Johnston RE. Nonmucosal alphavirus vaccination stimulates a mucosal inductive environment in the peripheral draining lymph node, *Journal of Immunology* 2008 Jul 1;181(1):574-85.
- 46) Ichinohe T, **Iwasaki A**, Hasegawa H. Innate sensors of influenza virus: clues to developing better intranasal vaccines. *Expert Rev Vaccines*, 2008 Nov;7(9):1435-45. PMCID: PMC2724183.
- 47) Iijima, N., Linehan. M.M., Zamora, M., Butkus, D., Dunn R., Kehry, M.R., Laufer, T.M., **Iwasaki, A**. Dendritic cells and B cells maximize mucosal Th1 memory response to herpes simplex virus. *Journal of Experimental Medicine*, 2008 Dec 22;205(13):3041-52. PMCID: PMC2605233.
- 48) Iijima, N., Thompson, J.M., **Iwasaki, A**. Dendritic cells and macrophages in the genitourinary tract. *Mucosal Immunology*, 2008 Nov;1(6):451-9. PMCID: PMC2684461.

- 49) Ichinohe, T., Lee, H.K., Ogura, Y., Flavell, R., **Iwasaki A.** Inflammasome recognition of influenza virus is essential for adaptive immune responses. *Journal of Experimental Medicine* 2009 Jan 16;206(1):79-87. PMCID: PMC2626661.
- 50) Lee, H.K., Zamora, M., Linehan, M.M., Iijima, N., Gonzalez, D., Haberman, A., **Iwasaki, A.** Differential roles of migratory and resident DCs in T cell priming after mucosal or skin HSV-1 infection. *Journal of Experimental Medicine*, 2009 Feb 16;206(2):359-70. PMCID: PMC2646574.
- 51) Tal, M.C., Sasai, M., Lee, H.K., Yordy, B., Shadel, G.S., **Iwasaki, A.** Absence of autophagy results in reactive oxygen species-dependent amplification of RLR signaling. *Proc. Natl. Acad. Sci. USA.*, 2009 Feb 24;106(8):2770-5. PMCID: PMC2650341.
- 52) **Iwasaki, A.** Local advantage: skin DCs prime, skin memory T cells protect. *Nature Immunology*, 2009 May;10(5):451-3, PMID: 19381136, NIHMSID: 468547phagosome.
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Patent Title: CD4T Cells Provide Antibody Access to Immunoprivileged Tissue. Filed May 16, 2016 for US provisional patent application. Co-inventor: Norifumi Iijima.

Patent Title: Interferon Production Using Short RNA Duplexes. United States Patent Application 20160046943. Co-Inventors: Anna Pyle, Dahai Luo, Andrew Kohlway, David Rawling

Patent Title: Compositions and Methods of Vaccination. Filed May 17, 2012 for US provisional patent application. PCT/US13/29965 Co-inventor: Haina Shin

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCÉDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF SANDRA
HERNANDEZ IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

Supplemental 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. I also serve on various public health commissions.

2. I previously submitted a declaration in this case on April 20, 2020. I submit this second declaration after reviewing Defendants' discovery responses, Plaintiffs' declarations, and visual images of Mesa Verde and Yuba County Jail. These materials confirm my views expressed in my first declaration, which I incorporate by reference here.

A. Covid-19 Continues to Spread Throughout the United States and California.

3. In the month since my previous declaration, COVID-19 has continued to spread exponentially in the United States. The U.S. now has over 1.5 million confirmed COVID-19 cases; more than five times than the next highest country.¹ California has over 80,000 confirmed cases, the fifth highest of any state.² In reality, the number of positive cases is likely much higher. The U.S. still has much work to do in making testing more accessible. The United States currently has administered approximately eight tests per confirmed case. This trails many other countries.³ By comparison, Germany has 18.6 tests per confirmed case; South Korea has 69.9 tests per confirmed case; and New Zealand has 207.1 tests per confirmed case. These figures indicate that testing shortages continue to exist in America.

4. Sadly, the United States has reported over 93,000 COVID-19 deaths. California has reported over 3,000 deaths.⁵ These numbers continue to grow each day.

5. There continues to be community spread of COVID-19 cases in the two county sites of the detention centers at issue in this litigation. Kern County has 1,571 confirmed cases among residents and 10 confirmed cases among non-residents.⁶ Yuba County and Sutter County have 68 total cases.⁷

6. There has been a significant growth of confirmed cases of COVID-19 within ICE facilities across the country, and there is unequivocal evidence that the actual number of COVID-19 cases is far higher than the number of cases confirmed. As of May 19, 2020, 1,145 detainees, 44 ICE employees at detention centers, and 110 ICE employees not assigned to ICE detention centers have tested positive for COVID-19.⁸ One detainee is already confirmed to have

¹ Johns Hopkins University of Medicine, Coronavirus Resource Center, <https://coronavirus.jhu.edu/map.html>.

² Johns Hopkins University of Medicine, Coronavirus Resource Center <https://coronavirus.jhu.edu/us-map>.

³ University of Oxford, <https://ourworldindata.org/grapher/number-of-covid-19-tests-per-confirmed-case>.

⁴ Johns Hopkins University of Medicine, Coronavirus Resource Center <https://coronavirus.jhu.edu/map.html>.

⁵ *Id.*

⁶ <https://www.bakersfield.com/>.

⁷ <https://www.yuba.org/coronavirus/>.

⁸ <https://www.ice.gov/coronavirus#wcm-survey-target-id>.

died in custody of COVID-19. The number of positive cases of persons in ICE detention is certainly higher than the confirmed cases. The positive test rate for ICE detainees is 52% (1,145/2,194), meaning that one out of every two detainees who are tested is confirmed positive. Consider that the national positive test rate for COVID-19 tests is approximately 13%.⁹ A widespread testing campaign would result in both a lower positive test rate and a greater number of positive tests because it would capture people who are COVID-positive but asymptomatic positive tests, as well as others with COVID-19 who should be but haven't been tested.¹⁰ The relatively low number of positive tests is necessarily a sign of severe under-testing and a sign of a significant number of unconfirmed, but present, COVID-19 infection in ICE detention centers.

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

7. California was the first state in the nation to order its residents to stay home to slow the spread of COVID-19. The goal in taking this swift action was to limit the growth of new cases and maintain the medical infrastructure necessary to treat the influx of COVID-19 cases.

8. California has developed four phases of modifying its stay-at-home order. The first phase is aimed at making it consistently safer for essential workers, including grocery employees, nurses, and other front-line personnel. The first phase focused on procuring sufficient protective equipment, developing a more robust testing program, and training a contact tracing team. The goal was to protect essential workers. California has indicated it has passed the first phase.

9. The second phase of the reopening plan is to permit some low-risk business and public spaces to reopen. This includes factories that can operate with social distancing measures in place, retail stores with curbside pick-up, and some child care facilities. Notwithstanding this gradual phase-two reopening, social distancing measures and protective equipment requirements remain in place.

10. The third phase involves reopening higher-risk workplaces, such as hair salons, gyms, movie theaters, and churches. Again, even in phase three, social distancing measures will remain in place. The fourth phase includes a broader reopening of the California economy, including conventions, concerts, and sporting events. Governor Newsom has indicated that phase four is months away.

11. Regardless of the current phase, California has recommended that all higher-risk individuals stay home.

12. The guiding factor in California's tiered approach to reopening the economy is reducing densely populated settings. Lifting statewide shelter-in-place orders has been gradual with careful measures. Fundamental to all four phases are the ability to socially distance, a robust testing program, and contact tracing. Mass gatherings will still be prohibited. Social distancing measures will remain in place.

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/testing-in-us.html>.

¹⁰ ICE does not publish the statistics for the number of employees tested.

C. The Risk of an Outbreak Remains High at Mesa Verde and Yuba County Jail.

13. Public officials should not be lulled into a false sense of security. The pandemic continues to pose an unprecedented threat to public health. That threat is particularly acute in detention centers like Mesa Verde Detention Center and Yuba County Jail.

14. Public health officials have been bracing for a second wave of infection as more people circulate within their communities. As more members of the community rejoin the general public, the risk of community transmission into detention facilities is increased.

15. Detention staff, vendors, and visitors enter and exit the facilities each day, bringing with them potential virus from the outside community. The more members of the community that rejoin the public, the higher the likelihood of bringing the virus into these facilities.

16. It remains in the interest of public health to release detainees from detention centers. The unnecessary detention of individuals in congregate settings in the midst of a pandemic risks an exponential spread of infection within the facility.

17. Despite modest improvement in testing rates, and flat trends in hospitalizations and intensive care admissions, densely populated facilities that share common environmental factors with Mesa Verde and Yuba remain most at risk. For example, in Los Angeles County, as of May 19, 2020, nearly one quarter of all confirmed COVID-19 cases have come from staff or residents in congregate settings (9,747/40,847) such as nursing homes. Similarly, as of that same date, approximately half of the COVID-19 deaths (990/1,970) came from congregate settings. These high case and death rates confirm the risk, particularly in light of the vast resources and public health focus on preventing outbreaks at nursing homes and other shared living facilities.

18. Outbreak is particularly pernicious in congregate settings because of the combination of indoor facilities, dense populations, and asymptomatic transmission. This risk is present even when facilities take preventative measures. For example, at a skilled nursing home in Kings County, Washington, the facility implemented enhanced infection-control measures in response to community awareness of COVID-19. Nursing staff assessed residents twice daily for COVID-19 symptoms; health care personnel were given oral temperature checks before each shift, and all staff were regularly screened for symptoms. On March 1, 2020, one member of the health care staff tested positive on March 1.¹¹ Two days later, the first resident tested positive. Twenty-three days after that, 64% of the facility (48/76) tested positive, with 27 of those residents being asymptomatic. The case fatality rate was 26%. In addition, 26 members of the staff tested positive. This example demonstrates the risk of congregate settings, and the inadequacies of symptom-based control measures.

19. In light of the heightened risk posed to congregate settings, other officials responsible for densely populated environments have heeded the call of public health experts. For example, California State University—which has 23 campuses and 480,000 students within its system—

¹¹ Arons M., et al, “Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility,” *New England Journal of Medicine*, (Apr. 24, 2020), <https://www.nejm.org/doi/full/10.1056/NEJMoa2008457>.

announced it would be transitioning to primarily online classes for the fall 2020 semester to protect the health and well-being of its students, faculty, staff, and communities.¹²

20. The same risks attendant in nursing homes and college dorms are present in detention facilities like Mesa Verde and Yuba. Living in a densely populated, indoor facility increases the risk of outbreak. Any outbreak strains the surrounding medical infrastructure and unnecessarily places lives at risk.

21. The risk of transmission in congregate settings remains very high, and the best measures to prevent infection in the absence of a vaccine or treatment are limiting congregate settings wherever possible and ensuring adequate social distancing where congregate settings are unavoidable.

22. The need to implement preventative measures, and particularly in congregate settings, should continue after any community-wide shelter-in-place orders end. To argue otherwise is dangerous and invites infection. The risk of infection for Mesa Verde and Yuba will, if anything, heighten as California advances in its phased reopening.

23. Any relaxation of shelter-in-place orders will still have many facets of public health protection that are not present at Yuba County Jail and Mesa Verde, including social distancing and required or recommended use of personal protective equipment. And relaxation of shelter-in-place orders is done in conjunction with increased access to testing. The current lack of testing at Yuba County Jail and Mesa Verde is incompatible with relaxing COVID-19 protections.

24. For these reasons, the serious risk of harm remains present and will continue even if the greater California or national leadership relaxes some currently existing COVID-19 preventive measures. Relaxing safety measures or increasing population levels within the facility could have dire consequences on detainees, staff and the surrounding health infrastructure.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.

Executed on May 21, 2020, in San Francisco, California.



Sandra R. Hernandez, MD

¹² Gordon, L., CSU chancellor explains decision to keep most fall classes online, *The Mercury News*, (May 17, 2020), <https://www.mercurynews.com/2020/05/17/csu-chancellor-explains-decision-to-keep-most-fall-classes-online/>.



Sandra R. Hernández, MD
President & CEO
California Health Care Foundation

Dr. Sandra R. Hernández became president and CEO of the California Health Care Foundation in January 2014. CHCF is an independent, nonprofit philanthropy with assets of more than \$700 million, headquartered in Oakland, California, and dedicated to improving California's health care system so that all Californians — especially those with low-incomes — can get the care they need.

Prior to joining CHCF, Dr. Hernández was CEO of The San Francisco Foundation, which she led for 16 years. She previously served as director of public health for the City and County of San Francisco.

Dr. Hernández is an assistant clinical professor at the University of California, San Francisco, School of Medicine and a leadership council member of the UCSF Institute for Global Health Sciences. She practiced at San Francisco General Hospital in the AIDS clinic from 1984 to 2016. She is 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.

Originally from Tucson, Arizona, she spent much of her childhood in rural New Mexico with her grandparents. There she came to honor and appreciate her Mexican culture and its intrinsic values of community and public service. Her love of science and math was nourished by her father, a self-educated engineer.

Dr. Hernández serves as a board member of Covered California, a commissioner of the Healthy California for All Commission, a trustee of the Reno-based Western Asbestos Settlement Trust, and as an independent director of First Republic Bank. She is a member of the Public Policy Institute of California's Statewide Leadership Council, the United States of Care Founder's Council, the Well Being Trust Advisory Council, and the National Academy of Medicine's planning committee for convening around the future of health services research.

Her earlier affiliations include President Clinton's Commission on Consumer Protection and Quality in the Healthcare Industry, and two Institute of Medicine committees: one on the Consequences of Uninsurance, and another on the Implementation of Antiviral Medication Strategies for an Influenza Pandemic.

Dr. Hernández is a former board member of Grantmakers In Health, the Council on Foundations, the California Managed Risk Medical Insurance Board, the Yale University President's Council, the UCSF Chancellor's Advisory Board, and the UCSF Clinical and Translational Science Institute Advisory Board. She co-chaired San Francisco's Universal Healthcare Council, which designed Healthy San Francisco, an innovative health access program for the uninsured.



Sandra R. Hernández, MD
President & CEO
California Health Care Foundation

Education

M.D., Tufts University School of Medicine, 1984, Boston, MA
B.A., Psychology, Yale University, 1979, New Haven, CT
W. K. Kellogg Fellowship
John F. Kennedy School of Government Local and State Executive
Program Certificate
Honorary Doctorate, California Institute of Integral Studies, 2006, San
Francisco, CA

Medical Licensure

Medical Board of California
Physician and Surgeon, 1986–Present

Medical Training

Residency, Primary Care/Internal Medicine
San Francisco General Hospital
University of California, San Francisco, 1984–1987

Language Competency

English and Spanish

Current Employment

California Health Care Foundation
Oakland, CA
January 2014–Present

Employment Experience

Chief Executive Officer
The San Francisco Foundation
September 1997–December 2013

Assistant Clinical Professor
School of Medicine
University of California, San Francisco
July 1992–Present

Director of Health
City and County of San Francisco
Department of Public Health
January 1994–August 1997

County Health Officer and Deputy Director
Community Public Health Services and AIDS
San Francisco Department of Public Health
November 1992–January 1994

Acting Medical Director
Community Public Health Services
San Francisco Department of Public Health
September 1991–November 1992

Director, AIDS Office
San Francisco Department of Public Health
February 1990–November 1992

Branch Chief, Health Resources and Services
AIDS Office
San Francisco Department of Public Health
1988–1990

Current Appointments and Public Service

Healthy California for All Commission

Commissioner

December 2019–Present

United States of Care

Founder’s Council

March 2018–Present

Well Being Trust

Advisory Council

March 2018–Present

Covered California

Board of Directors

February 2018–Present

National Academy of Medicine

Planning Committee for the Future of Health Services Research

July 2017–Present

Board of Regents, University of California

Health Services Committee

March 2016–Present

West Coast Healthcare Executive Summit

Member 2014–Present

Public Policy Institute of California Statewide Leadership Council

April 2011–Present

First Republic Bank

Board of Directors

August 2010–Present

Institute for Global Health Sciences Advisory Council

University of California, San Francisco

2009–present

Western Asbestos Settlement Trust

Appointed Trustee

California Superior Court

April 2004–Present

Academic Appointments

Clinical and Translational Science Institute Clinical Research Center

External Advisory Board
University of California, San Francisco
2007–2017

San Francisco General Hospital
Faculty, Department of Medicine
Medical Attending
AIDS Clinic (Ward 86)
1987–2016

Pediatric Leadership for the Underserved
Advisory Council
University of California, San Francisco
2006–2016

Program in Medical Education for the Urban Underserved
Advisory Council
University of California, San Francisco
2006–2016

Chancellor's Advisory Board
University of California, San Francisco
2010–2014

Campus Facilities Improvement Association
University of California, San Francisco
2008–2012

Past Appointments
and Public Service

Betty Irene Moore School of Nursing at UC Davis
National Advisory Council
2016–2019

Health IT Strategic Planning and Innovation Workgroup
Member
2014–2017

Yale University
University Council Member
2011–2016

Blue Shield of California Foundation
Board of Directors
2010–2014

The Center for Investigative Reporting
Board of Directors
2011–2014

Federal Reserve Bank of San Francisco
Economic Advisory Councilmember
2011–2014

National Academy of Sciences Institute of Medicine
Committee on Implementation of Antiviral Medication Strategies for an
Influenza Pandemic
2007–2008

Council on Foundations
Board of Directors
Committee on Inclusiveness, Ethics and Practices
2006–2009

Co-Chair, Mayor's Universal Healthcare Council
San Francisco Health Access Plan
Mayor Gavin Newsom
2006

Chair, Mayor's Blue-Ribbon Committee on the Future Location of San
Francisco General Hospital
Mayor Gavin Newsom
2005

National Academy of Sciences Institute of Medicine
Committee on the Consequences of the Uninsured
2003–2004

Lucile Packard Children's Hospital
Board of Directors and Chair of Public Policy Committee
2003–2010

Corporation for Supportive Housing
Board of Directors, Chair Governance Committee
1997–2008

Blackbaud, Inc.
Board of Directors and Audit Committee
2002–2006

California State Senate-Appointed Member
Managed Risk Medical Insurance Board
1998–2007

Kaiser Permanente
Member, National Advisory Council on Professional and Organizational
Ethics
1997–2003

Grantmakers in Health
Board of Directors
1998–2003

Presidential Appointee
President Clinton's Commission on Quality and Consumer Protection in
the Health Industry
Co-Chair, Subcommittee on Roles and Responsibilities of Public/Private
Care Purchasers and Oversight Organizations
1997–1998

San Francisco Health Plan
Founding Chair, Board of Directors
1995–1998

Scientific Advisory Committee on Antiviral Therapy
Federal Drug Administration
1995–1998

Honors / Awards

San Francisco Business Times
Most Admired CEO
2019

University of California, San Francisco
Alumni Excellence Award
2015

Openhouse, San Francisco
Adelman/Gurevitch Founders Award
2015

Hispanic Business Magazine
Woman of the Year
2008

Tufts Medicine Magazine
Cover
2008

San Francisco Planning and Urban Research Association
Silver Spur Award
2008

Women Healthcare Executives

Woman of the Year

2007

Modern Healthcare Magazine

One of Ten Healthcare Leaders for the Next Century: Up and Comers

1997

League of Women Voters of San Francisco

Women Who Could Be President Award

1993

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCEDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF SARAH H.
ALLEN, M.D. IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO# 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO# 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

DECLARATION OF SARAH ALLEN, M.D.

I, Sarah Allen, declare as follows:

1. I am a Professor of Medicine in the Division of Infectious Diseases at the University of New Mexico. I am a member of the Infectious Diseases Society of America.
2. I earned a Bachelor's degree and a Master's degree from Stanford University. I earned a Medical Degree from the University of Louisville School of Medicine. I completed my residency in Internal Medicine and my fellowship in Infectious Diseases at the University of New Mexico. I have spent the past 31 years treating patients, conducting research, and teaching medical students, residents and fellows in the field of Infectious Diseases.
3. I am licensed to practice medicine in the states of New Mexico and Texas. I am board certified in internal medicine and infectious diseases. I continue to maintain my medical practice. I am on the staff of a university hospital with over 500 beds and four intensive care units. I regularly treat critically ill patients with a variety of infections caused by bacteria, fungi and viruses, and consult and advise on the treatment and infection control of hospitalized patients with severe acute respiratory syndrome coronavirus 2, SARS-CoV-2 ("COVID-19").
4. I have published scholarly articles, review articles, a book, and book chapters, and other scholarly writings on issues relating to the care of Infectious Disease patients. A copy of my curriculum vitae is attached as Exhibit A.
5. I am not being compensated for providing my testimony in this case.
6. In support of this declaration, I have relied on my scientific and specialized knowledge, skill, experience, training, and education. I have also reviewed the following materials:
 - a. Declarations of Fermin Trujillo Lopez, Gilberto Pablo Perez, Jose Mejia Rosas, Juan Aguilar Castaneda, Livia Pinheiro, Maynor Oxlaj Siguantay, Pravindar Singh, Arias Marroquin, Asif Masoom Qazi, and Aylaliyah Burru:
 - b. Defendants' Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Supplemental Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Second Supplemental Responses to Plaintiffs' Initial Set of Interrogatories; Defendants' Third Supplemental Responses to Plaintiffs' Initial Set of Interrogatories; Yuba Detainee List 5.15.2020; and MV Detainee List 5.15.2020.
 - c. Defendants' Response to Plaintiffs' Memorandum on Common Issues in Bail Review Process.

A. COVID-19 is Caused by a Newly Discovered Virus That Spreads Rapidly.

7. COVID-19 is disease caused by a novel coronavirus that first emerged in Wuhan, China in December 2019. Coronaviruses are a family of viruses that are known to cause respiratory

infections. There is currently no vaccine or cure for COVID-19. Current treatment is supportive. Clinical research into various medications, vaccines, respiratory support and management of multi-organ failure is actively ongoing.

8. COVID-19 is a highly contagious virus that is transmitted from person to person. The virus is most commonly contracted when a person inhales respiratory droplets or small droplet nuclei. The virus may also infect by coming in contact with human mucous membranes, primarily from a person touching an infected surface and then touching his or her face (mouth, nose or eyes mucus membranes). Evidence indicates that aerosolized COVID-19 can remain suspended and viable in the air for hours, and on surfaces for up to three days or longer, depending on the surface.¹ These numerous modes of transmission of COVID-19 have resulted in extremely high viral infectivity.

9. Due to the ease with which COVID-19 is transmitted, the human population's current lack of specific immunity to this novel virus, and the lack of a vaccine, COVID-19 has reached pandemic levels around the globe and in the United States. As of the date of this declaration, there are more than 5 million known COVID-19 cases in the world; 1,551,853 known COVID-19 cases in the United States; and 93,439 reported COVID-19 related deaths in the United States.² Due to limited testing in the United States and globally, these numbers are believed to be underestimates of the actual number of cases and related deaths.

B. COVID-19 Affects More Than the Lungs.

10. COVID-19 is a respiratory illness caused by a virus that enters the body via respiratory, oral, and eye mucous membranes. The virus adheres to the outer membranes of human cells, then invades the cell where it takes over cellular machinery and makes numerous copies of itself before leaving the cell (the cell may then undergo apoptosis or cellular death) to infect other cells in a similar fashion. Mathematically, this viral infection is exponential, on a number's scale, akin to a nuclear reaction.

11. In an effort to control this type of overwhelming viral infection, the body's immune system responds to COVID-19 cellular infection by production of cytokines which are a variety of substances secreted by immune system cells. Cytokines are intended to help the host fight the viral infection. However, when the immune system's response is too robust, the cytokine response can lead to the so-called "cytokine storm" which can be disadvantageous to the host, cause a rapid deterioration in the patient's condition (around symptom day 10), and can result in death.³

12. Coronavirus infection is not limited to the lungs but infects multiple organ systems, including the cardiovascular system and the kidneys. COVID-19 is known to create a hypercoagulable state resulting in inappropriate clotting of the blood, thereby causing strokes,

¹ Aerosol and Surface Stability of SARS-COV-2 as Compared with SARS-CoV-1. *N. Engl. J. Med.* (Apr. 16, 2020) https://www.nejm.org/doi/full/10.1056/NEJMc2004973?query=featured_home

² Johns Hopkins University, Coronavirus Resource Center, <https://coronavirus.jhu.edu/map.html>.

³ Mason RJ. Pathogenesis of COVID-19 from a cell biologic perspective. *Eur Respir J* 2020; in press (<https://doi.org/10.1183/13993003.00607-2020>).

even in young people. Other manifestations of the COVID-19 hypercoagulable state include deep venous thrombosis, pulmonary embolism, and infarcts in the blood supply to the heart, the musculoskeletal system and other parts of the human vascular system.

13. Although elderly patients are at high risk for poor outcomes from COVID-19 infection, COVID-19 can also have devastating effects on otherwise healthy young patients. On March 16, 2020, the CDC reported that 38% of the then-current COVID-19 hospitalizations in the United States were in patients between 20 and 54 years of age.⁴ In New York State, approximately one-third of COVID-19 fatalities are in patients younger than 70.⁵

14. A common indication for hospitalization in COVID-19 patients is bilateral interstitial pneumonia with hypoxia (low oxygen saturation) and systemic inflammatory response syndrome, frequently requiring intensive care life support with artificial respiration, medication support for severe shock, extracorporeal membrane oxygenation (ECMO), and dialysis. Many of these cases are ultimately fatal.

15. Even for those COVID-19 patients who do recover, hospitalization and intensive care treatment for COVID-19 patients takes a considerable toll on patients, medical resources, and medical personnel. The requirement for mechanical ventilation can cause long-term lung functionality damage and other organ damage. Some of these COVID-caused conditions will either kill the patient or cause long-term medical problems, such as compromised hearts, strokes, limb weakness, brain damage, among other effects.

C. Many Common Preexisting Medical Conditions Place Patients at Increased Risk of Severe Clinical Outcomes from COVID-19.

16. I am aware that in this litigation, the Defendants have taken the position that only the following nine medical or environmental conditions increase a person's vulnerability to a severe outcome upon contracting COVID-19: (1) being 65 years of age or older; (2) living in a nursing home or long-term care facility; (3) chronic lung disease or moderate to severe asthma; (4) serious heart conditions; (5) being immunocompromised; (6) severe obesity (defined as having a body mass index of 40 or higher); (7) diabetes; (8) chronic kidney disease undergoing dialysis; and (9) liver disease. I am also aware that Defendants claim to rely on information from the Centers for Disease Control and Prevention (CDC) to support this position. However, to my knowledge, the CDC lists a far broader range of medical conditions that can increase vulnerability to COVID-19, and moreover, that there are additional conditions beyond those listed by the CDC that, according to recognized sources in the medical literature, are also associated with worse outcomes. These conditions that increase a person's medical vulnerability to COVID-19 include those discussed below.

⁴ Maragakis, L., Coronavirus and COVID-19: Younger Adults Are At Risk, Too; <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-and-covid-19-younger-adults-are-at-risk-too>.

⁵ New York State Department of Health, Fatalities, <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no>

17. **Asthma:** Asthma is a chronic medical condition in which a person's airways become inflamed. Inflammation results in extra mucous production, which can make breathing difficult and trigger coughing and shortness of breath. Asthma is generally not considered curable and requires chronic management. Patients with asthma are at an increased risk of a severe outcome if they contract COVID-19.⁶ COVID-19 infection, with or without pneumonia, can trigger an asthma attack which can be difficult to manage.

18. **Diabetes:** Type 1 and type 2 diabetes both cause chronic multi-organ system damage, which includes impairment of the immune system, and the cardiovascular and renal systems disease. The CDC has recognized diabetes as a risk factor for severe COVID-19.⁷ Diabetes is the second most common comorbidity present in COVID-19 fatalities in New York State, presenting in more than 8,000 deaths, more than 1/3 of every recorded fatality in New York.⁸ Those numbers are even higher than earlier data. In a February 2020 study of 52 patients in Wuhan, China, 22% of non-survivors had diabetes.⁹ A review of later studies found a twofold increase in the incidence of patients in intensive care having diabetes, and a threefold increase in mortality with patients with diabetes compared to the general mortality of COVID-19 in China.¹⁰ In the United States, a study of 1122 patients admitted to 88 U.S. hospitals between March 1, 2020 and April 6, 2020 showed approximately 40% had diabetes or uncontrolled hyperglycemia on admission, and death rates were more than four times higher among this same group compared to patients with normal glucose control.¹¹

Pre-diabetes is a condition in which there is already measurable glucose intolerance, and is essentially on a spectrum with type 2 diabetes. (Prediabetes is diagnosed when the hemoglobin A1C is between 5.7 and 6.4%; type 2 diabetes is diagnosed when the hemoglobin A1C is 5.7% or higher.) It has been established that patients with prediabetes have increased complications with cardiovascular disease. As discussed above, uncontrolled hyperglycemia, which would be expected to include patients with pre-diabetes, is associated with increased risk for severe COVID-19 disease. For these reasons, it is expected that pre-diabetics will also be found to have worse outcomes when compared to patients with normal glucose though given the novelty of the virus there is insufficient data at this time.

19. **HIV:** Patients with human immunodeficiency virus (HIV) have compromised immune systems. It is expected HIV patients who acquire COVID-19 will be at higher risk for poor outcomes and the CDC and other medical experts have recognized HIV as a risk factor for severe

⁶ CDC, "Coronavirus Disease 2019: People Who Are At Higher Risk," <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

⁷ *Id.*

⁸ New York Department of Health, Fatalities Tracker. <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no>

⁹ Yang X, Yu Y, Xu J, et al. Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study, *Lancet*, (Feb. 24, 2020) [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30079-5/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30079-5/fulltext)

¹⁰ Madsbad S., COVID-19 Infection in People with Diabetes, *Touch Endocrinology*, <https://www.touchendocrinology.com/insight/covid-19-infection-in-people-with-diabetes/>

¹¹ Bode B, Garrett V, Messler J, McFarland R, et al. Glycemic Characteristics and Clinical Outcomes of COVID-19 Patients Hospitalized in the United States; <https://glytecsystems.com/wp-content/uploads/JDST-Glytec-Covid-Research.pdf>

COVID-19.¹² HIV disease itself is associated with metabolic derangements that cause the same comorbidities that are established to increase risk of COVID-19 morbidity and mortality, including diabetes, hypercholesterolemia, cardiovascular disease, and hypercoagulability.

20. **Obesity:** Obesity is defined as a body mass index above 30. People with obesity are at risk for severe outcomes, in part because they have higher resistance in their airways, lower lung volumes, and weaker respiratory muscles—all features that are critical to fight COVID-19. Obese patients are more likely to develop pneumonia. Though the CDC only lists severe obesity (body mass index over 40) as a risk factor,¹³ recent medical data suggests the risk of severe COVID-19 begins at a lower level of obesity. A recent study of 3,615 COVID-19 patients at a New York City hospital revealed that patients younger than 60 with a body mass index between 30-34 were 2.0 and 1.8 times more likely to be admitted to acute care and to critical care, respectively, compared to individuals with a body mass index less than 30.¹⁴ Likewise, patients younger than 60 with a body mass index greater than 35 were 2.2 and 3.6 times more likely to be admitted to acute care and to critical care, respectively, compared to patients in the same age category who had a mass body index less than 30. The study concluded that obesity, not just severe obesity, is a previously unrecognized risk factor for hospital admission and need for critical care.

21. **Hypertension:** Hypertension, or high blood pressure, occurs when the body's arterioles narrow or stiffen, causing blood to exert excessive pressure against the vessel walls, forcing the heart to work harder. The American College of Cardiology (ACC) and American Heart Association (AHA) have defined hypertension as systolic readings (the upper number) of 130-139 mm Hg or diastolic readings (the lower number) of 80-89 mm Hg.¹⁵ The ACC/AHA revised

¹² CDC, "Coronavirus Disease 2019: People Who Are At Higher Risk," <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

¹³ CDC, "Coronavirus Disease 2019: People Who Are At Higher Risk," Apr. 15, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>

¹⁴ Lighter, J. et al., Obesity in patients younger than 60 years is a risk factor for Covid-19 hospital admission, *Clinical Infectious Diseases*, (Apr. 9, 2020) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7184372/pdf/ciaa415.pdf>

¹⁵ "2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines," *J. of American College of Cardiology* 2018;71:e127-e248, May 7, 2018, at <https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/11/09/11/41/2017-guideline-for-high-blood-pressure-in-adults>. See also Lei Fang et al., "Are Patients with Hypertension and Diabetes Mellitus at Increased Risk for COVID-19 Infection?" *The Lancet*, Mar. 11, 2020 at [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30116-8/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30116-8/fulltext); Ying-Ying Zheng et al., "COVID-19 and the Cardiovascular System," *Nature Reviews: Cardiology*, Mar. 5, 2020, at <https://www.nature.com/articles/s41569-020-0360-5?fbclid=IwAR3w4wcTno9A798v1fuYbALPLUHU5dNsVNVFKDc6GW-6yED2mXcyxRJY7dc> ("In one study, among the patients with severe symptoms of COVID-19, 58% had hypertension. . . According to mortality data released by the [National Health Commission of China], 35% of patients with SARS-CoV-2 infection had a history of hypertension."); Fei Zhou et al., "Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China: A Retrospective Cohort Study," *The Lancet*, Vol. 395, Issue 10229, Mar. 28-Apr. 3, 2020, at <https://www.sciencedirect.com/science/article/pii/S0140673620305663> ("Comorbidities were present in nearly half of patients [hospitalized with a severe form of COVID-19 in one study], with hypertension being the most common comorbidity").

guidelines require two elevated readings for a finding of hypertension.¹⁶ (Even a blood pressure reading of 120/80 is now considered abnormal and is labeled as “prehypertension.”) The CDC and various studies have recognized hypertension as a comorbidity associated with heightened risk of severe COVID-19, adverse outcomes, and case fatality.¹⁷ In particular, case fatality has been found to be seven times higher for individuals with hypertension than for those without comorbidities.¹⁸ Hypertension is the most common comorbidity in COVID-19 fatalities in New York State.¹⁹ As data from the New York Department of Health indicates, hypertension of a comorbidity for patients across all age ranges, with over 1,000 patients younger than 60 with hypertension dying from COVID-19.²⁰ Hypertension is a serious risk for patients, independent of the patient’s age.

22. **Cardiovascular disease or heart conditions:** Cardiovascular disease is also a common comorbidity in patients with severe COVID-19 outcomes.²¹ Pre-existing cardiovascular disease include history of heart attack, stroke, arrhythmia, or congestive heart failure. Cardiovascular disease was a common comorbidity in patients with two previous coronaviruses, SARS and MERS.^{22 23} Early COVID-19 data suggests a similar association between pre-existing cardiovascular disease and severe clinical outcomes. In addition, COVID-19 can actually *cause* each of these conditions as well. One study concluded that myocardial injury was present in more than a quarter of critical cases and presented in two patterns: acute myocardial injury and dysfunction on presentation, and myocardial injury that develops as illness severity intensifies.²⁴

23. **History of Smoking:** Smoking and e-cigarette use increases the risk and severity of pulmonary infections because of damage to the upper airways. Smoking also causes a decrease in pulmonary immune function. Previous studies demonstrated that smokers had a higher risk of infection and mortality from the coronavirus MERS.²⁵ Medical research suggests a similar risk

¹⁶ *Id.* (“Prior to labeling a person with hypertension, it is important to use an average based on ≥ 2 readings obtained on ≥ 2 occasions to estimate the individual’s level of BP.”).

¹⁷ “Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease,” dated March 30, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

¹⁸ *Id.* (citing Novel Coronavirus Pneumonia Emergency Response Epidemiology T. [The epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) in China]. *Zhonghua Liu Xing Bing Xue Za Zhi*. 2020;41(2):145-151.).

¹⁹ New York Department of Health, Fatalities Tracker. <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no>

²⁰ *Id.*

²¹ CDC, “Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)” (updated Apr. 6, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html> (identifying cardiovascular disease as a “Risk Factor[] for Severe Illness” and “associated with increased illness severity and adverse outcomes,” with a case fatality rate of 10.5% compared to 0.9% absent comorbidities); CDC, “Coronavirus Disease 2019: People Who Are At Higher Risk,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html> (individuals with “serious heart conditions” at higher risk for severe COVID-19).

²² Chan JWM, et al.. Short term outcome and risk factors for adverse clinical outcomes in adults with severe acute respiratory syndrome (SARS). *Thorax*. 2003;58:686-689

²³ Booth CM, et al., Clinical features and short-term outcomes of 144 patients with SARS in the greater Toronto area. *Jama*. 2003;289:2801-2809.

²⁴ Clerkin K. et al., Coronavirus Disease 2019 (COVID-19) and Cardiovascular Disease, *AHA Journal*, <https://www.ahajournals.org/doi/pdf/10.1161/CIRCULATIONAHA.120.046941>

²⁵ Park JE, Jung S, Kim A, Park JE. MERS transmission and risk factors: a systematic review. *BMC Public Health*. 2018;18(1):574. .doi: 10.1186/s12889-018-5484-8.

between smoking and severe clinical outcomes for COVID-19 patients and the CDC has recognized a history of smoking as a risk factor for severe COVID-19.²⁶ A recent meta-analysis of COVID-19 studies associated smoking and progression of COVID-19, with smokers having 1.91-times the odds of progression of COVID-19 severity than non-smokers.²⁷ The study concluded that “among those people assessed as smokers[,] risk of disease progression is significantly increased.”²⁸

24. **Cancer:** COVID-19 patients with cancer are vulnerable to severe clinical outcomes.²⁹ Cancer patients are generally considered to have a suppressed immune system which may be multifactorial as a result of the cancer itself or as a result of treatment. A recent study of patients in 14 hospitals in Wuhan, China revealed that compared with COVID-19 patients without cancer, patients with cancer had higher observed death rates, higher rates of ICU admission, higher rates of having at least one severe or critical symptom, and higher chances of requiring mechanical ventilation.³⁰ The study concluded that “patients with cancer deteriorated more rapidly than those without cancer.”³¹ In addition, COVID-19 infection in patients with cancer would be expected to increase the mortality and morbidity from the cancer itself as COVID-19 infection would be expected to delay the ability for the patient to undergo a variety of cancer treatments. Patients with active infections are not usually given chemotherapy, and patients with COVID-19 are often restricted from receiving chemotherapy in a cancer clinic with other patients. Chemotherapy is usually given under medical supervision and not at a patient’s home.

25. **Chronic kidney disease:** Chronic kidney disease has been identified as a risk factor for severe COVID-19.³² Chronic kidney disease impacts the body’s ability to filter blood appropriately, to regulate the body’s fluid and acidic status, to contribute to the production of red blood cells, to regulate and contribute to the production of factors that contribute to bone health, and to contribute to blood pressure control. COVID-19 viral particles have been found at autopsy, indicating the kidney is one of its direct organ targets. Acute kidney injury in COVID-19 infection has been shown to result in high levels of protein loss in the urine, hematuria, and

²⁶ CDC, “Coronavirus Disease 2019: People Who Are At Higher Risk,” Apr. 15, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html> (CDC affirms that smoking “can cause a person to be immunocompromised” and thus at heightened risk of COVID-19). *See also* “Smoking or Vaping May Increase the Risk of Severe Coronavirus Infection,” Scientific American (March 17, 2020) at <https://www.scientificamerican.com/article/smoking-or-vaping-may-increase-the-risk-of-a-severe-coronavirus-infection1/?amp> (National Institutes of Health warn that, “[b]ecause it attacks the lungs, the coronavirus that causes COVID-19 could be an especially serious threat to those who smoke tobacco or marijuana or who vape.”).

²⁷ Patanavanich R. et al., Smoking is Associated with COVID-19 Progression: A Meta-Analysis, *Nicotine and Tobacco Research*, (May 13, 2020), <https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntaa082/5835834>

²⁸ *Id.*

²⁹ CDC, “Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)” (updated Apr. 6, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html> (identifying cancer as a “Risk Factor[] for Severe Illness” and “associated with increased illness severity and adverse outcomes,” with a case fatality rate of 6% compared to 0.9% absent comorbidities).

³⁰ Dai, M., et al., Patients with cancer appear more vulnerable to SARS-COV-2: a multi-center study during the COVID-19 outbreak, *American Association for Cancer Research*, (Apr. 28, 2020) <https://cancerdiscovery.aacrjournals.org/content/early/2020/04/24/2159-8290.CD-20-0422.full-text.pdf>

³¹ *Id.*

³² CDC, “Coronavirus Disease 2019: People Who Are At Higher Risk,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

impairment of function. A recent cohort study of 701 patients demonstrated an association between kidney disease and in-hospital deaths. Acute kidney injury occurred in 5.1% of patients and “demonstrated that kidney disease had a significantly higher risk for in-hospital death.”³³ Patients with pre-existing renal disease requiring hemodialysis, which is usually performed in a dialysis clinic, are at risk for acquiring COVID-19 given the group setting in most dialysis units. Patients with chronic renal failure managed with renal transplant are highly immunosuppressed and also carry a risk for adverse outcomes from COVID-19. Patients with chronic kidney disease, whether managed with dialysis or transplant, may be unable to spike a fever when they are ill with an infection. They may be chronically fatigued from the kidney failure, or short of breath from fluid overload. These common characteristics in end-stage renal disease may make it harder to pick-up COVID-19 infection since fever, shortness of breath and fatigue from COVID-19 patients might be inappropriately attributed to the renal disease.

26. ***Chronic respiratory or lung disease.*** Patients with chronic lung disease are more susceptible to severe clinical outcomes from COVID-19 infection.³⁴ Lung disease from chronic obstructive pulmonary disease or emphysema, results in obstructed airflow from the lungs, often with shortness of breath and/or hypoxia at baseline. A recent systematic review and meta-analysis demonstrated an association between COPD and COVID-19 severity and mortality.³⁵ Patients with chronic aspiration, which often occurs in patients with neurologic disorders that affect their ability to swallow properly, can have chronic lung disease and would be expected to have a higher morbidity and mortality from COVID-19.

27. ***Liver disease.*** Liver disease is common in the United States, often caused by untreated Hepatitis C, alcohol use disorder, or even obesity which can result in “fatty liver.” All of these entities can lead to cirrhosis, which is often underdiagnosed until end-stage liver disease results. Liver disease has been linked to severe COVID-19 outcomes as demonstrated in a recent meta-analysis of 3,428 patients with confirmed COVID-19 cases in China.³⁶ The CDC has recognized liver disease as a risk factor for severe COVID-19.³⁷

28. ***Hepatitis C:*** Hepatitis C is a viral infection that can cause liver inflammation but has many extra-hepatic manifestations, such as vasculitis, stroke, ischemic heart disease, renal,

³³ Cheng, Y. et al, Kidney disease is associated with in-hospital death of patients with COVID-19, *Kidney International*, Vol. 97, Issue 5, 829-838 (May 2020) [https://www.kidney-international.org/article/S0085-2538\(20\)30255-6/fulltext](https://www.kidney-international.org/article/S0085-2538(20)30255-6/fulltext)

³⁴ CDC, “Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)” (updated Apr. 6, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html> (identifying chronic respiratory disease as a “Risk Factor[] for Severe Illness” and “associated with increased illness severity and adverse outcomes,” with a case fatality rate of 6% compared to 0.9% absent comorbidities); CDC, “Coronavirus Disease 2019: People Who Are At Higher Risk,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

³⁵ Alqahtani, J.S. et al., Prevalence, Severity and Mortality associated with COPD and Smoking in patients with COVID-19: A Rapid Systematic Review and Meta-Analysis, *PLOS One*, (May 11, 2020), <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0233147&type=printable>

³⁶ Parohan, M., et al. Liver injury is associated with severe Coronavirus disease 2019 (COVID-19) infection: a systematic review and meta-analysis of retrospective studies, *MedRxiv* (Apr. 9, 2020) <https://www.ncbi.nlm.nih.gov/pubmed/32386449>

³⁷ CDC, “Coronavirus Disease 2019: People Who Are At Higher Risk,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

metabolic and central nervous system diseases. Each of these hepatitis C manifestations has also been found in COVID-19 patients. While little has been published about hepatitis C patients who have been infected with COVID-19, we would expect worse outcomes for Hepatitis C patients and the CDC has recognized Hepatitis C as a risk factor for COVID-19.³⁸ The risk of severe clinical outcomes is particularly acute in patients with advanced Hepatitis C with cirrhosis, hepatorenal syndrome, or one of the malignancies seen in Hepatitis C patients such as hepatocellular carcinoma or lymphoma.

29. ***Immunocompromised Conditions:*** Patients with immunocompromised systems are at risk for more severe outcomes,³⁹ and in total, these diseases are more common in the general population than one might think. Immunocompromised patients have diminished or incomplete immune system function, which hinders their ability to fight and recover from infections. Immunodeficiency is commonly present in refugee populations (which are among the ICE detainee population and also share some characteristics) from malnutrition. There are many additional, often common, diseases or conditions that can cause immunodeficiency including diabetes, human immunodeficiency virus (HIV), cancer, inflammatory bowel disease such as Crohn's disease or chronic ulcerative colitis, rheumatoid arthritis, lupus, other autoimmune disorders, end-stage renal disease, Cushing's disease or Cushing's syndrome with high cortisol production, genetic diseases such as Trisomy 21 (Down's syndrome), diseases that require steroid administration such as COPD, adrenal insufficiency, antibody deficiencies, medications that suppress their white cell counts (neutropenia), diseases requiring "biologic agents" or other immunosuppressives such as psoriasis or psoriatic arthritis.

30. ***Autoimmune disorders:*** Patients with any number of autoimmune disorders are at risk of severe COVID-19 outcomes because their immune systems have limited ability to fight disease. Several of these diseases are discussed in detail in the above paragraph.

31. ***Endocrine disorders:*** In addition to diabetes, other disorders that are likely to be associated with more severe COVID-19 infection include adrenal insufficiency (Addison's disease) which requires steroid replacement. It would also be expected that patients with Cushing's Disease or Cushing's syndrome, which creates excessive cortisol states, would likely experience increased risk as these disorders are associated with immunodeficiency from the cortisol.⁴⁰

32. ***Corticosteroid use*** and use of other immune modulating medications are believed to place such patients at higher risk for COVID-19 morbidity and mortality as discussed in the section above on immunocompromised conditions as well as the section on chronic lung diseases.⁴¹

³⁸ *Id.*

³⁹ CDC, "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission," Mar. 12, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>, 10.

⁴⁰ *Id.*

⁴¹ CDC, "Coronavirus Disease 2019: People Who Are At Higher Risk," <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>

33. **History of head injuries:** Individuals with a history of head injuries may be at heightened risk for severe COVID-19 outcomes although research in this area has been limited thus far. However, neurologic and central nervous system damage is known to be caused by COVID-19. COVID-19 is expected to further impair patients with pre-existing brain damage. Examples of such “acute on chronic” manifestations in neurologic disease can be seen when patients with pre-existing brain damage suffer from hypoxia (low oxygen), or infection in the brain. Expected manifestations might include increase risk of seizures as well as further limitations of intellectual ability, and ability to perform activities of daily living, requirement for increased assistance by caretakers.

34. **Prior organ transplant.** Organ transplant recipients are at high risk for infection and poor outcomes.⁴² Transplant recipients require immunosuppressive therapy to prevent organ rejection. Transplant recipients usually have other co-morbidities, such as from the disease that may have caused the original organ damage. Research regarding the association between transplant recipients and severe COVID-19 outcomes is ongoing. But early research indicates a strong association between transplant and severe outcome. A study of 90 transplant recipients with COVID-19 in New York City hospitals were compared to international cohorts of non-transplant patients hospitalized with COVID-19 with transplant patients in New York City showing higher rates of severe disease (39% vs. 6.1%) and mortality (24% v. 1.4%-4.3%).⁴³

35. **Blood disorders:** Patients with relatively common blood disorders such as sickle cell and thalassemia are very likely at increased risk for severe COVID-19 outcomes.⁴⁴ Hemoglobin disorders can lead to multi-organ complications including kidney, heart, and liver disease that are established risk factors for severe COVID-19.⁴⁵ Sickle cell disease is further associated with veno-occlusive disease, strokes and thromboembolic disease and these sickle cell complications are likely to be triggered by COVID-19 induced hypoxia (low oxygen). Data is currently being collected by the international COVID-19 sickle cell disease registry and by the ASH Registry.

36. **Neurological and neurodevelopment conditions:** Neurological disorders, such as cerebral infarction and dementia and a history of stroke, place patients at heightened risk of severe COVID-19 complications. Cerebral infarction damages the tissues in the brain due to loss of oxygen. Recent data from Wuhan, China, reported neurological complications in 36% of 214 patients with COVID-19; acute cerebrovascular disease (mainly ischemic stroke) was more common among 88 patients with severe COVID-19 than those with non-severe disease (5.7% vs 0.8%).⁴⁶ Neurodevelopmental conditions, such as intellectual disabilities and moderate to severe developmental delay, are also believed to be risk factors for severe COVID-19.

⁴² *Id.*

⁴³ Pereira, M.R. et al., COVI-19 in solid organ transplant recipients: Initial report from the US epicenter, *American Journal of Transplantation*, (Apr. 24, 2020) <https://doi.org/10.1111/ajt.15941>

⁴⁴ CDC, “Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission,” Mar. 12, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>, 10.

⁴⁵ CDC, Groups at Higher Risk, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html#hemoglobin-disorders>

⁴⁶ Mao L , Jin H , Wang M , et al . Neurologic manifestations of hospitalized patients with coronavirus disease 2019 in Wuhan, China. *JAMA Neurol* 2020 (Apr. 11, 2020), <https://jamanetwork.com/journals/jamaneurology/fullarticle/2764549>

37. **Age:** Most press accounts have classified the risk to elderly COVID-19 to include only very elderly patients. I understand that Defendants have taken the position that anyone younger than 65 is not vulnerable to severe COVID-19 infection outcome based on age. The medical research does not support this theory. While the very elderly in their 80's are most at risk for death, the median age of hospitalized patients with severe COVID-19 in a large retrospective study in China was only 52 years.⁴⁷ The case fatality rate for individuals aged 60-69 hovers around 3.5%, an alarmingly high rate.⁴⁸ Based on evolving data, researchers recently concluded that while morbidity may be highest for society's oldest members, "anyone older than 50 is far from safe."⁴⁹ Age should be understood as a spectrum of risk. The older the patient, the more likely they are to be hospitalized or have severe clinical outcomes. My interpretation of the data is that starting at 40 years of age, patients have an increasingly higher risk for poor outcome.⁵⁰

38. **High Cholesterol.** High serum cholesterol is associated with severe COVID-19 outcomes. About 25-30% of lipids in our cell membranes is made of cholesterol. Early research suggests that high cholesterol enhances binding of COVID-19 to the cell surface in the endocytic pathway by facilitating viral entry.⁵¹ Data from New York state identifies hyperlipidemia as the third most common comorbidity among COVID-19 fatalities.⁵²

39. **Tuberculosis:** Tuberculosis, both active and latent, is a medical vulnerability for COVID-19 patients. Tuberculosis is a disease caused by a bacteria that attacks the lungs. It too is highly contagious. Tuberculosis can damage the immune system and make patients more vulnerable to infectious diseases. Early studies of confirmed cases in Shenyang, China found that *Mycobacteria tuberculosis*, the pathogen that causes tuberculosis, was present in 36.11% of COVID-19 cases in the study, including 7 of 9 severe cases. The study concluded that tuberculosis (active and latent) increased both a patient's susceptibility to COVID-19 and increased the COVID-19 severity.⁵³

40. **Mental illness:** Most mental illness has been found to suppress the immune response. Particularly, post-traumatic stress disorder, bipolar, depression, anxiety, and stress affect the immune system by increasing the stress hormone cortisol. Because any impairment of the immune system makes the body more susceptible to virus, patients with pre-existing mental illness are likely susceptible to severe outcomes of COVID-19.

⁴⁷ Guan W., Ni Z., Hu Y., et al. Clinical characteristics of coronavirus disease 2019 in China. N. Engl. J. Med. (2020) doi: 10.1056/NEJMoa2002032.

⁴⁸ Vishnevetsky, Anastasia, and Michael Levy. "Rethinking high-risk groups in COVID-19." *Multiple sclerosis and related disorders*, vol. 42 102139. 22 Apr. 2020, doi:10.1016/j.msard.2020.102139

⁴⁹ *Id.*

⁵⁰ See, e.g., CDC, "Laboratory-Confirmed COVID-19-Associated Hospitalizations" (updated May 9, 2020), at https://gis.cdc.gov/grasp/covidnet/COVID19_3.html

⁵¹ Wang H., The role of high cholesterol in age-related COVID19 lethality, bioRxiv (May 9, 2020), <https://doi.org/10.1101/2020.05.09.086249>.

⁵² New York State Department of Health, Covid-19 Fatalities, <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no>

⁵³ Yu Chen et al., *Active or Latent Tuberculosis Increases Susceptibility to COVID-19 and Disease Severity*, (Mar. 16, 2020), at <https://www.medrxiv.org/content/10.1101/2020.03.10.20033795v1.full.pdf>

The association between mental illness and poor viral suppression manifests in many diseases, including infectious diseases like HIV.⁵⁴ Depression disorders are similarly associated with worse outcomes in patients with diabetes and coronary heart disease.^{55 56} Infectious disease doctors expect a similar relationship between mental illness and adverse COVID-19 clinical outcomes.

Mental illness also compounds the difficulties in caring for physical illnesses. Understanding and complying with recommended and necessary treatments can be very difficult for patients with limited coping skills. In addition, COVID-19 patients are supposed to be isolated and unable to have visitors, which further leads to depression.

D. Necessary Precautions for Patients with Preexisting Medical Conditions.

41. Because all COVID-19 patients can potentially experience severe outcomes, everyone should exercise caution, avoid crowds, maintain social distancing, and practice good hygiene. But precautions are particularly important for those with pre-existing medical conditions because they are at risk for a severe outcome if they contract COVID-19.

42. The comorbidities described above affect the lung, immune, and vascular systems. Because the virus attacks the lungs, can trigger a chaotic immune response, and attacks major organs, which has a blood supply (i.e. vascular system), the damage caused by COVID-19 infection is widespread and can lead to multi-system organ damage or death.

43. While masks and other personal protective equipment decrease infectivity rates, they are still insufficient to completely protect people from contracting the virus. A recent study found that surgical and cotton masks were ineffective in filtering COVID-19 during coughs by infected patients.⁵⁷ The study found a greater contamination on the outer mask surface than inner mask surface. This is likely due to the aerodynamic features and the small aerosols of COVID-19 generated during high-velocity coughs. While N-95 respirator masks likely protect against most particle dissemination, there is a nationwide scarcity of these masks. Based on my review of the current medical literature, the types of masks provided to detainees do not fully or adequately protect against the spread of the virus. While wearing a mask is better than not wearing a mask, it is not a substitute for social distancing.

44. High-risk individuals should avoid crowds to reduce the risk of being exposed. As mentioned, there is no cure for COVID-19. The only meaningful way to protect against infection is to avoid others who are or may be infected. Because of the high rate of

⁵⁴ Yehia BR, Stephens-Shield AJ, Momplaisir F, et al. Health Outcomes of HIV-Infected People with Mental Illness. *AIDS Behav.* 2015;19(8):1491-1500. doi:10.1007/s10461-015-1080-4; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4527875/>

⁵⁵ Pouwer F, Nefs G, Nouwen A. Adverse effects of depression on glycemic control and health outcomes in people with diabetes: a review. *Endocrinol Metab Clin North Am.* 2013;42(3):529–44.

⁵⁶ Barth J, Schumacher M, Herrmann-Lingen C. Depression as a risk factor for mortality in patients with coronary heart disease: a meta-analysis. *Psychosom Med.* 2004;66(6):802–13.

⁵⁷ Bae. S. et al., Effectiveness of Surgical and Cotton Masks in Blocking SARS-CoV-2: A Controlled Comparison in 4 Patients, *Annals of Internal Medicine*, (Apr. 6, 2020)

asymptomatic transmission, any densely crowded area is dangerous. That risk is intensified in crowded, indoor facilities because individuals are exposed to more viral particles.

45. I understand there has been virtually no testing performed at Mesa Verde and Yuba County Jail. That is dangerous and irresponsible. Because the virus can be transmitted by asymptomatic carriers, there is a very real risk of mass infection.

46. I have reviewed the interrogatory responses and spreadsheets documenting the population levels at Mesa Verde and Yuba County Jail. The conditions at Mesa Verde and Yuba County Jail are ripe for outbreak. These are densely populated, indoor facilities, with prolonged, close interaction between inhabitants, and no way to evaluate for asymptomatic infectious carriers.

47. An outbreak at Mesa Verde and Yuba County (if it has not happened already) is very likely. Any person currently detained with pre-existing medical conditions is at high risk of death or severe complications, such as organ failure, lung failure, heart failure, stroke, or requirement of mechanical ventilation. Approximately 80% of COVID-19 patients placed on ventilators do not survive.

48. There is a clear association between vulnerable medical conditions and severe or fatal outcomes. Though early, the scientific literature is robust. There is a significant risk that individuals will experience severe complications or die if the current conditions which prevent recommended social distancing and adequate hygiene at these facilities continue unabated.

E. The Impact of COVID-19 on the Medical Infrastructure.

49. An outbreak at Mesa Verde and Yuba County would also severely strain the surrounding medical infrastructure. Treating COVID-19 patients—particularly those with medical vulnerabilities—is resource intensive. Hospitals around the country have been working diligently to source more ICU beds and mechanical ventilators. But the reality is those resources are in high demand at non-pandemic public health levels. An outbreak strains local medical resources and could lead to every physician's worst nightmare: choosing how to allocate life-saving medical resources. In my personal experience, I have cared for one patient on extracorporeal membrane oxygenation (ECMO) who is alert and communicative but cannot be weaned from this treatment. This is an emotional issue for providers, the family and the patient, knowing the ECMO machine being used may be taking a survival chance away from another patient.

50. Hospitals also face a shortage of N-95 respirators and other personal protective equipment. Medical professionals treating COVID-19 patients require gloves, medical gowns, respirators, and face shields. Those materials are in short supply. Due to the highly contagious nature of the virus, each treating medical team needs to regown and change personal protective equipment for every patient contact. Thus, each new hospitalized COVID-19 patient contributes to the strain on personal protective equipment and other medical equipment.

51. As of the date of this declaration, only one antiviral drug has been conditionally approved to treat severe COVID-19 symptoms: remdesivir. Remdesivir does not cure COVID-19, but early research suggests it can shorten hospitalization times by about four days. While this may

seem small to patients and their families, the impact of remdesivir is expected to be high. The ability to reduce hospitalization by four days improves long-term recoveries and allows hospitals to treat more patients.

52. The demand for remdesivir currently outpaces the supply. Hospitals that do have access to remdesivir will have limited quantities. Each new case of COVID-19 potentially takes that limited supply of the drug from another patient. Accordingly, taking all possible steps to limit the spread of COVID-19 is incredibly important while drug research and remdesivir production remains in its early stages.

53. As is well documented, COVID-19 is highly contagious. Each infected person infects two to three other patients on average. The spread of the virus has been exponential. On February 20, 2020, there were 15 cases in the United States; today there are over 1.5 million.⁵⁸ Protecting detainees from the spread of COVID-19 should not only be viewed through the exclusive lens of protecting that one person; it should also be viewed from the perspective of protecting all people who will be exposed to the virus as a result of that person's infection. An outbreak at a congregate facility increases the likelihood of spread to other detainees as well as the staff, their families, their neighbors, their faith communities, and the medical personnel and first responders who will ultimately treat them. We have an obligation to take every step possible to protect each person from infection for our common benefit.

54. The paramount concern in preventing an outbreak is saving human life. But treating COVID-19 patients is very expensive for hospitals because it requires increased staffing of nurses, physicians and other support personnel, expensive equipment, and novel treatments. Costs of COVID-19-related ICU admissions range from \$20,000-\$160,000 per patient.⁵⁹ Moreover, because COVID-19 disproportionately affect low-income or uninsured patients, hospitals regularly cover these costs. Hospitals around the country have cancelled non-essential operations and visits to focus on treating COVID cases and limit unnecessary exposure to the virus. This has had a severe impact on hospital finances.

55. Further, COVID-19 outbreaks strain the community hospital resources, which leads to business decisions that may ultimately impact certain hospitals' ability to treat a broader population of patients. Accordingly, an outbreak at Mesa Verde or Yuba County could harm the public by using scarce resources and contributing to difficult choices hospitals must make that affect their ability to treat other patient populations in the future. Moreover, outbreaks can scare patients who would otherwise seek treatment from receiving the care they need. It has already been reported that the rate of patients seeking care for myocardial infarctions has dropped substantially. In one study of Northern California hospitals, the weekly rates of hospitalization for acute myocardial infarctions decreased by up to 48% during the COVID-19 period compared to non-COVID periods.⁶⁰

⁵⁸ Johns Hopkins University, Coronavirus Resource Center, U.S. Cumulative Cases, <https://coronavirus.jhu.edu/data/cumulative-cases>

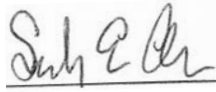
⁵⁹ Forman, H., Social Distance: How much does it cost to get COVID-19? *The Atlantic*, (Apr. 27, 2020).

⁶⁰ Soloman, M. et al., The Covid-19 Pandemic and the Incidence of Acute Myocardial Infarction, *New England Journal of Medicine*, Letter Report, (May 19, 2020), https://www.nejm.org/doi/full/10.1056/NEJMc2015630?query=featured_home

56. The current conditions at Yuba County Jail and Mesa Verde are very dangerous. Every person in those facilities, staff and detainees, is at risk of infection. Multiple medical vulnerabilities exacerbate infection and contribute to a higher likelihood of severe or fatal clinical outcomes. It is very likely people will become infected and die because of the unsafe conditions at these facilities.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.

Signed on May 21, 2020 in Albuquerque, New Mexico.

A handwritten signature in black ink, appearing to read "Sarah E. Allen", is positioned above a horizontal line.

Sarah E. Allen, M.D.
Professor of Medicine
University of New Mexico
Division of Infectious Diseases,
DoIM MSC 10-5550, 1 University
Albuquerque, New Mexico 87131

Updated 12/27/2019

CURRICULUM VITAE**SARAH E. ALLEN, MD**

Address: 1523 Eagle Ridge RD NE
Albuquerque NM 87122

Licensure: New Mexico, 88-110, current
Texas, M1002, current
Republic of Kenya, 7085/95, expired
Controlled Substance Registration
Texas: current
New Mexico: current

Certification: DEA: current
American Board of Internal Medicine, 10/88
Diplomat in Infectious Diseases, 11/92
Recertification 11/02 and 12/12

Educational History:	ID Fellowship 7/89 - 7/91	University of New Mexico Albuquerque, New Mexico Division of Infectious Diseases
	Chief Resident 7/88 - 6/89	University of New Mexico Albuquerque, New Mexico Department of Medicine
	Residency 7/86 - 6/88	University of New Mexico Albuquerque, New Mexico Internal Medicine
	Internship 6/85 - 6/86	Children's Hospital of San Francisco (now Pacific Medical Center) San Francisco, California Internal Medicine
	Medical School MD, 1985	University of Louisville School of Medicine Louisville, Kentucky
	Undergraduate BA, 1980	Human Biology Stanford University Stanford, California
	Graduate School MS, 1980	Biological Sciences Stanford University Stanford, California

Employment History: University of New Mexico

Professor of Medicine, 8/2012 – present
Director, Outpatient Treatment Center, 2012 - 2015
Director, Outpatient Antibiotic Treatment Center, 2012 - 2015
Director, Fellowship Program in Infectious Diseases, 2012 - 2015
Member, Core Competency Committee, ID Fellowship, 2014-15
Member, Education Committee, ID Fellowship, 2014-2015
*Member, Program Evaluation Committee, ID Fellowship, 2017-present

Baylor College of Medicine

Associate Professor of Medicine 2005-2012
Associate Director, Adult Cystic Fibrosis Center 2005-2012
Co-director, Baylor Clinic Infusion Center 2008-2010
Department of Medicine, Division of Infectious Disease

University of New Mexico

Professor of Medicine, 6/2005
Associate Professor of Medicine, 7/97-5/2005
Assistant Professor of Medicine, 7/91 – 6/97
Director, Home IV Antibiotic Clinic 7/2000-5/2005, 8/12/2012-11/1/2015
Director, Adult CF Clinic 1/2003-5/2005
Divisions of Infectious Disease/General Internal Medicine
Albuquerque, New Mexico

Moi University

Visiting Professor
August 1995
Eldoret, Kenya

Professional Recognition:

Listed as a “Best Rated Doctors near Albuquerque, New Mexico”
www.rate.mds.com/best-doctors/NM/ALBUQUERQUE#Infectious+Disease

2010 Doctor’s Choice: One of 390 of Houston’s Best Physicians. Health & Fitness Sports Magazine.

2004 Women on the Move Nomination, YMCA, Albuquerque, New Mexico.

Tell us Who’s a Star, University Hospital recognition for clinic personnel, February 11, 2003.

Faculty Teaching Excellence Award for Residency/Fellowship Years, 1998-99

Valued Employee Nominee, University of New Mexico Hospital, 1996

An Apple for the Teacher Certificate of Recognition, University of New Mexico, 1991 – 1992

Upjohn Company Recognition for Teaching, University of New Mexico, 1989

Professional Societies:

Infectious Diseases Society of America
2012-present

Texas Medical Association
2005-2012

American College of Physicians
1991 – 2000
Council Member 1993 – 1995

Greater Albuquerque Medical Association, Member 1996

Infectious Diseases Society of New Mexico, Member
1996 – 2005, 2012 – present

New Mexico Medical Society Medical-Legal Panel, 1993 – 1995

Invited Lectures:

Parting Shot—Getting Adult Immunizations Right, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 21, 2018.

The New C. Difficile—Epidemiology, Treatment and Prevention, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 21, 2018.

C. Diff: Review and Update, 47th Annual Fall Clinics Program, Montrose Memorial Hospital, Montrose, Colorado, September 21, 2018.

Infectious Diseases Potpourri: Hosts, Syndromes, Bugs and Drugs, 47th Annual Fall Clinics Program Montrose Memorial Hospital, Montrose, Colorado, September 21, 2018.

Parting Shot—Getting Adult Immunizations Right, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 22, 2017.

The New C. Difficile—Epidemiology, Treatment and Prevention, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 22, 2017.

Parting Shot—Getting Adult Immunizations Right, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 16, 2016.

The New C. Difficile—Epidemiology, Treatment and Prevention, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 16, 2016.

Infections in Triathletes
UNM Division of Infectious Diseases, teleconference
May 2012

Management of Mycobacterial infections in Post-Lung transplant patients, Infectious Diseases Journal Club, Baylor College of Medicine, Summer 2011.

Lung Transplantation in an HIV patient, Infectious Diseases Journal Club, Baylor College of Medicine, Spring 2010.

Organ donation from infected patients, Infectious Diseases Journal Club, Baylor College of Medicine, Fall 2009

Community Acquired Pneumonia, Pulmonary Fellow Conference, Baylor College of Medicine, 2009.

Multi-drug resistant Pseudomonas bacteremia in the immediate post-operative period in a lung transplant patient, Citywide Infectious Diseases Conference, May 7, 2008.

The Nuts and Bolts of Antibiotics: An Update and Review for Orthopedists, Department of Orthopedic Surgery, Baylor College of Medicine, April 28, 2008.

Cystic Fibrosis for Pulmonary Fellows, Baylor College of Medicine, April 21, 2008

Pyoderma gangrenosa, Citywide Infectious Diseases conference, Texas Medical Center, Houston, Texas, April 16, 2008.

Disease Management of Cystic Fibrosis in Adults, St. Luke's Episcopal Hospital Grand Rounds, Houston, Texas, September 17, 2007.

Patient with Multi-Drug Resistant Pseudomonas, Citywide Infectious Diseases Conference, Texas Medical Center, Houston, Texas, March 28, 2007.

Patient with Mycobacterial Breast Implant Infection, Citywide Infectious Diseases Conference, Texas Medical Center, Houston, Texas, October 4, 2006.

Cystic Fibrosis for Infectious Diseases Fellows, Baylor College of Medicine, Houston, Texas, March 30, 2006.

Patient with Acute Demyelinating Encephalomyelitis (ADEM), Citywide Infectious Diseases Conference, Texas Medical Center, Houston, Texas, January 25, 2006.

Cerebral Mucor in a Non-immunocompromised Patient with Recurrent Sinusitis, Citywide Infectious Diseases Conference, Texas Medical Center, Houston, Texas, October 6, 2005

HIV for the General Internist, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 12, 2004.

Infectious Diseases Question and Answer, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 12, 2004.

Antibiotics for Nurse Practitioners, UNM School of Nursing, September 8, 2004.

Antibiotics for Senior PA students, University of New Mexico, August 9, 2004.

Treatment of Gram Positive Infections: The Good and Bad News, Infectious Diseases and General Medicine Pot Pourri, VA Hospital, Albuquerque, June 4, 2004.

Antibiotics for Nurse Practitioners, UNM School of Nursing, May 4, 2004.
HIV and Tuberculosis: The Tale of Two Tragedies. UNM Department of Biology, April 29, 2004.

ENT Manifestations of HIV: Davison of Otolaryngology, AIDS Education and Training Center, UNM, Albuquerque, April 19, 2004,

Rational Use of Antibiotics: Lovelace Clinic Foundation, Albuquerque, February 26, 2004.

Antibiotics: Something Old, Something New, UNM Department of Medicine Grand Rounds, January 8, 2004.

Antibiotics Update and Review, Lovelace Clinic Foundation, Albuquerque, November 20, 2003.

Infectious Diseases Question and Answer, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 2003.

HIV Update for Internists, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 2003.

Antibiotics: Review and Update, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe, October 2003.

Tuberculosis, New Mexico Environmental Health Conference, Albuquerque, October 20, 2003.

Adult Cystic Fibrosis: It Takes An Internist, UNM Department of Medicine Grand Rounds, July 24, 2003.

Highly Active Antiretroviral Therapy (HAART) 101, New Mexico AIDS Services, AIDS Education and Training Center, July 22, 2003.

Oral Manifestations of HIV and Basic Biology of HIV, UNM School of Dentistry, AIDS Education and Training Center, June 27, 2003.

HIV and AIDS, UNM Department of Biology students, April 24, 2003.

FUO in and AIDS Patient, Infectious Diseases Society of New Mexico, Albuquerque, April 22, 2003.

Tuberculosis, Presentation to Congresswoman Heather Wilson, Albuquerque, March 7, 2003.

Rational Use of Antibiotics, Presbyterian Hospital CME, February 4, 2003.

Tuberculosis, Health Care for the Homeless, Albuquerque, February 26, 2003.

Tuberculosis: Ancient and Modern Disease, Institute for Medieval Studies, Albuquerque. February 8, 2003.

Antibiotics, St. Joe's Regional Medical Center, Albuquerque, February 4, 2003.

Vaccines for the Primary Care Provider, 2003 Annual Women's Health Care Seminar, Albuquerque, January 31, 2003.

Rational Use of Antibiotics Workshop, 2003 Annual Women's Health Care Seminar, Albuquerque, January 31, 2003.

November 15, 2002. Rational Use of Antibiotics, CME Presentation, Espanola Hospital, Espanola, New Mexico.

October 20, 2002. Tuberculosis, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe.

October 20, 2002. Advances in Antiretroviral Therapy, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe.

October 20, 2002. Infectious Diseases Question and Answer, Update and Review of Internal Medicine, University of New Mexico and Beth Israel Deaconess Medical Center, Santa Fe.

September 25, 2002. Antibiotics: Review and Update, Lovelace Clinic Foundation, Albuquerque.

October 4, 2001. Infectious Disease Q & A, Update and Review of Internal Medicine 2001, Santa Fe.

October 2, 2001. Adult Immunizations, Update and Review of Internal Medicine 2001, Santa Fe.

June 1, 2001. Antibiotics Update, Infectious Diseases Pot Pourri, Albuquerque.

July 12, 2000. Antibiotics. Family Practice Grand Rounds. University of New Mexico, Albuquerque, New Mexico.

June 16, 2000. Adult Immunizations, Infectious Diseases Pot Pourri, Albuquerque.

October 13, 1999. Advances in Antiretroviral Therapy, Update and Review of Internal Medicine, Santa Fe.

October 13, 1999. Infectious Diseases Q & A. Update and Review of Internal Medicine, Santa Fe.

June 8, 1999. Antibiotics for Nurse Practitioners, Midwives and Clinical Specialists. UNM Nursing Education, Kim Litwack RN Director.

October 29, 1999. Antibiotics for Neurosurgeons. University of New Mexico. Albuquerque, New Mexico.

June 4, 1999. HIV and Pregnancy. Infectious Diseases Pot Pourri. Albuquerque, New Mexico.

April 22, 1999. Antibiotics—Review and Update. Department of Medicine Grand Rounds.

March 5, 1999. Antibiotics—Review and Update. Advances in Primary Care 1999. Albuquerque, New Mexico.

February 9, 1999. Antibiotic Use for OB/GYN Infections. Department of Obstetrics and Gynecology, Presbyterian Healthcare Services. Albuquerque, New Mexico.

October 14, 1998. Antibiotics. Surgery and Emergency Medicine Grand Rounds. Texas Tech, El Paso, Texas.

October 14, 1998. Tuberculosis. Update and Review of Internal Medicine 1998. Albuquerque, New Mexico.

October 14, 1998. Infectious Diseases Q & A. Update and Review of Internal Medicine 1998. Albuquerque, New Mexico.

September 11, 1998. HIV and Pregnancy. High Risk Obstetrics Conference. Albuquerque, New Mexico.

August 6, 1998. Tuberculosis. University Hospital Clinic Personnel. Albuquerque, New Mexico.

June 12, 1998. Routine Health Maintenance for the Healthy Adult Female. Department of Obstetrics and Gynecology. University of New Mexico, Albuquerque.

June 4, 1998. Antimicrobial Pharmacology. Three Hour Lecture. University of New Mexico College of Nursing.

March 25, 1998. Management of Basic Infections in Primary Care. Center for Alcohol and Substance Abuse and Addictions. Albuquerque, New Mexico.

March 20, 1998. HIV Medications. Advances in Primary Care 1998, Albuquerque, New Mexico.

February 10, 1998. E. Coli 0157:H7. Infectious Diseases Society of New Mexico. Albuquerque, New Mexico.

June 30, 1997. Highly Active Antiretroviral Therapy. Midland, Texas.

October 16, 1997. Tuberculosis. Update and Review of Internal Medicine 1997, University of New Mexico, Albuquerque, New Mexico.

October 16, 1997. Infectious Diseases Q & A. Update and Review of Internal Medicine 1997, University of New Mexico, Albuquerque, New Mexico.

May 16, 1997. Antibiotic Update. 60th Annual convention, New Mexico Osteopathic Medical Association, Santa Fe, New Mexico.

March 1, 1997. Immunizations: Adult. Advances in Primary Care 1997, Albuquerque, New Mexico.

December 18, 1996. Antibiotics Update. University of New Mexico Department of Family Practice Grand Rounds, Albuquerque, New Mexico.

October 25, 1996. Antibiotics. New Mexico Academy of Physician Assistants, Albuquerque, New Mexico.

October 22, 1996. Internal Medicine Wards in Eldoret, Kenya: Lessons from the Third World. Grand Rounds, St. Vincent's Hospital, Santa Fe, New Mexico.

October 18, 1996. Antibiotics Update. University of New Mexico Department of Obstetrics and Gynecology Grand Rounds, Albuquerque, New Mexico.

October 8, 1996. HIV-1 and HIV-2 in West Africa. Masters in Public Health Epidemiology Seminar, University of New Mexico, Albuquerque, New Mexico.

July 19, 1996. HIV/AIDS -- Old Realities, New Developments. United States Embassy, Abidjan, Cote d'Ivoire.

June 17, 1996. Women with HIV. Association of Women's Health, Obstetric and Neonatal Nurses, Albuquerque Chapter, Albuquerque, New Mexico.

June 7, 1996. Routine Adult Immunizations. St. Joseph's Infectious Diseases Potpourri, Albuquerque, New Mexico.

June 1996. Internal Medicine in Eldoret, Kenya: Lessons from the Third World. University of New Mexico Department of Medicine Grand Rounds, Albuquerque, New Mexico.

May 23, 1996. Medicine in Kenya. University Hospital Ambulatory Care Center 5th Floor Clinic Staff Meeting, Albuquerque, New Mexico.

May 22, 1996. Early Care of the HIV Patient, Education and Prevention. AIDS Education and Training Center. St. Vincent's Hospital, Santa Fe, New Mexico.

May 10, 1996. HIV/AIDS Prevention, Early Intervention, and Health Promotion. AIDS Education and Training Center, Taos, New Mexico.

March 22, 1996. HIV/AIDS Prevention, Early Intervention, and Health Promotion. Guadalupe Medical Center, Carlsbad, New Mexico.

March 21, 1996. HIV Update. AIDS Education and Training Center, Memorial Hospital, Las Cruces, New Mexico.

December 14, 1995. Medicine and Life in Kenya. Department of Medicine Staff Meeting, University of New Mexico, Albuquerque, New Mexico.

December 8, 1995. Routine Adult Immunizations. American College of Physicians New Mexico Scientific Meeting, Albuquerque, New Mexico.

November 2, 1995. Antibiotic Update. Guadalupe Medical Center, Carlsbad, New Mexico.

August 1995. Disorders of the Spleen and Asplenia. District Hospital, Eldoret, Kenya.

August 1995. HIV/AIDS in the United States. District Hospital, Eldoret, Kenya.

August 1995. Prognostic Labs in African Women with HIV. District Hospital, Eldoret, Kenya.

April 1995. Disorders of the Spleen and Asplenia. University of New Mexico Department of Medicine Grand Rounds, Albuquerque, New Mexico.

March 18, 1995, Antibiotic Update. Advances in Internal Medicine, Albuquerque, New Mexico.

February 3, 1995. Current Concepts in Antibiotic Therapy. Update: Infectious Disease Management, Medical Education Resources, Albuquerque, New Mexico.

January 27, 1995. Women and HIV. Conference on Women's Health Matters, St. Joseph Healthcare System, Albuquerque, New Mexico.

January 27, 1995. HIV 101. HIV/AIDS Counseling Issues, Technical Vocational Institute (TVI) Student Counselors, Albuquerque, New Mexico.

January 19, 1995. HIV Update and Women with HIV. Eddy County Medical Society, Carlsbad, New Mexico.

December 3, 1994. Approach to the Patient with Chronic Fatigue Syndrome. American College of Physicians New Mexico Scientific Meeting, Albuquerque, New Mexico.

December 1, 1994. HIV 101. HIV/AIDS Case Management Training, AIDS Education and Training Center, Las Cruces, New Mexico.

October 20, 1994. Epidemiology of HIV/AIDS in Women. HIV/AIDS Case Management Training, AIDS Education and Training Center, Albuquerque, New Mexico.

October 15, 1994. Antibiotic Update. Update: Infectious Disease Management. The Willow Creek Golf and Country Club, Oklahoma City, Oklahoma.

June 10, 1994. Chronic Fatigue Syndrome. New Mexico Infectious Disease Potpourri IV, Albuquerque, New Mexico.

May 4, 1994. Antibiotic Update. Big Springs, Texas.

Spring 1994. Antibiotic Update. Lubbock, Texas.

Spring 1994. Antibiotic Update. Midland, Texas.

April 30, 1994. Women and HIV. Panhandle Chapter of the Texas Academy of Family Physicians, Amarillo, Texas.

March 25, 1994. Approach to the Patient with Chronic Fatigue Syndrome. Advances in Internal Medicine, Albuquerque, New Mexico.

February 16, 1994. Use of Outpatient Antibiotics. New Mexico Physician Associates Association, Albuquerque, New Mexico.

October 1993. Antibiotic Drugs, Pharmacology Update. St. Joseph Healthcare System, Albuquerque, New Mexico.

August 3, 1993. Women and HIV. The Navajo Division of Social Services Eleventh Annual Children, Youth and Families Conference, Albuquerque, New Mexico.

August 1993. Antibiotic and Hantavirus Update. Zuni Pueblo, New Mexico.

July 8, 1993. Women and HIV Infections. Summer Primary Care Update 1993, Albuquerque, New Mexico.

June 27, 1993. HIV, Women and Abortion. New Mexico Primary Care Association, Joint Provider Retreat, Ruidoso, New Mexico.

May 1993. Vaccines. Ambulatory Care Center 5th Floor Nursing Staff Meeting, University of New Mexico, Albuquerque, New Mexico.

May 1993. Antibiotic Update. San Juan Medical Center, Farmington, New Mexico.

March 13, 1993. Immunization Guidelines -- Current Recommendations. Advances in Internal Medicine, Albuquerque, New Mexico.

April 1993. Women, HIV and Abortion. University of New Mexico Department of Medicine Grand Rounds, Albuquerque, New Mexico.

January 28, 1993. Needlesticks. Ambulatory Care Center 5th Floor Clinic Staff Meeting, University of New Mexico, Albuquerque, New Mexico.

July 1992. Early Intervention in HIV Care. Albuquerque Family Health Center, Albuquerque, New Mexico.

June 5, 1992. The Explosion of Hospital Antibiotics: A Dilemma for the Practitioner. Infectious Diseases Potpourri II, Albuquerque, New Mexico.

May 26, 1992. Antibiotic Update. Tucson, Arizona.

April 23, 1992. HIV and AIDS. Ambulatory Care Center 5th Floor Nursing and Clinic Staff Meeting, University of New Mexico, Albuquerque, New Mexico.

April 8, 1992. Clinical Aspects of HIV/AIDS. Gallup Indian Medical Center, AIDS Education and Training Center, Gallup, New Mexico.

March 17, 1992. Antibiotic Update. Poudre Valley Hospital, Denver, Colorado.

March 14, 1992. Antibiotic Update. Advances in Internal Medicine, Albuquerque, New Mexico.

January 23, 1992. Antibiotic Update. Phoenix, Arizona.

January 22, 1992. Antibiotic Update. Sacaton, Arizona.

January 21, 1992. Antibiotic Update. Tuba City, Arizona.

December 13, 1991. Antibiotic Update. Indian Health Service Hospital, Crownpoint, New Mexico.

December 13, 1991. Antibiotic Update. Indian Health Service Hospital, Fort Defiance, Arizona.

September 17, 1991. Antibiotic Update. Holbrook, Arizona.

September 17, 1991. Antibiotic Update. Indian Health Service Hospital, Ganado, Arizona.

September 17, 1991. Antibiotic Update. Whiteriver, Arizona.

March 25, 1991. Antibiotics. Grand Rounds. St. Vincent's Hospital, Santa Fe, New Mexico.

September 13, 1991. HIV Risk Behavior in Women Obtaining Abortions. St. Vincent's Hospital, Santa Fe, New Mexico.

Medical Students, Residents/Fellows and College Undergraduates:

Mentoring:

Daniel Lyle, undergraduate, applying to UNM Med School
Hospital Volunteer, shadows in OPAT clinic and on ID inpatient consults service. Have advised student on personal statement and other activities related to applying to medical school

Gaby Chacon, Master's student, Department of Biology, University of New Mexico. Hospital Volunteer, shadows on ID inpatient consult service and attends medical student tutorials. Advise student on application to medical school.

Tutorials for Transitions Block (Doctoring)

April 2019, 3 tutorials

Tutorials for ID Block

Fall 2016, 2 weekly tutorials

Fall, 2013, 5 weeks, bi-weekly tutorials

University of New Mexico Lectures or Learning Sessions

Mandell Club, Chapter 104, Osteomyelitis, UNM Infectious Diseases Division, October 31, 2019.

Mandell Club, Chapter 310, Prophylaxis and Empirical Therapy of Infection in Cancer Patients, UNM Infectious Diseases Division, September 5, 2019.

ID Case Conference: 52 year old female with cavitory pneumonia, PE and DVT, May 16, 2019.

Mandell Club, Chapter 107, Prosthetic Joint Infection, UNM Infectious Diseases Division, March 21, 2019.

Mandell Club, Chapter 56, Fever of Unknown Origin, UNM Infectious Diseases Division, December 20, 2018.

Mandell Club, Chapter 321, Immunizations, UNM Infectious Diseases Division, October 18, 2018.

Mandell Club, Chapter 245, Clostridium Difficile, UNM Infectious Diseases Division, August 16, 2018.

25-year-old female with wounds after breast reduction surgery, UNM Infectious Diseases Division, July 12, 2018.

A case of SIRS following abdominoplasty, UNM Infectious Diseases Division, June 14, 2018.

Mandell Club, Chapter 76, Peritonitis and Intraperitoneal Abscesses, UNM Infectious Diseases Division, May 24, 2018.

69-year-old female with a leg ulcer, UNM Infectious Diseases Division, March 1, 2018.

Mandell Club, Chapter 65, Oral, Head, Neck Infections: Lemierre Syndrome and Ludwig's Angina, February 8, 2018.

Mandell Club, Chapter 291, Cestodes (Tape worms), UNM Infectious Diseases Division, December 21, 2017.

Mandell Club, Chapter 277, Leishmania, UNM Infectious Diseases Division, September 28, 2017.

Mandell Club, Chapter 276, Malaria, UNM Infectious Diseases Division, July 27, 2017.

Mandell Club, Chapters 187, Rickettsiosis, Ehrlichioses, Anaplasmosis, June 15, 2017.

Mandell Club, Chapters 263 and 278, Madura Foot and Trypanosomiasis, May 25, 2017.

Mandell Faculty Club, Chapter 312, Risk Factors and Approaches to Infections in Transplant Recipients, March 16, 2017

Mandell Club, Chapters 265, 266, 267, Endemic Fungi Learning Session, UNM Infectious Diseases Division, January 5, 2017

Mandell Faculty Club, Chapter 310, Neutropenic Fever in Cancer Patients, December 15, 2016

Fever Masqueraders Learning Session, UNM Infectious Diseases Division, November 10 and November 17, 2016

Faculty Mandell Club, Chapters 241 and 168, Leptospirosis and Hantaviruses, November 17, 2016

Hematologic Hints in Infectious Diseases, UNM Infectious Diseases Division Learning Session, May 26, 2016.

Pericarditis Learning Session, UNM Infectious Diseases Division Learning Session, April 28, 2016.

Septic Arthritis and Bursitis, UNM Infectious Diseases Division Learning Session, January 21, 2016.

Fever and Fever of Unknown Origin, UNM School of Medicine, November 11, 2013

Infections in the Adult Cystic Fibrosis Patient, Infectious Diseases Fellows, May 9, 2013

Antibiotics for Family Practice
University of New Mexico, January 10, 2013

Fever of Unknown Origin
UNM Medical School, January 3, 2013

What It's Like to Have a Family and Practice Medicine: group discussion with medical students and faculty, April 15, 2004.

Antibiotics. Phase II Medical Students, Medicine Rotation Orientation, October 25, 2004, July 6, 2004, April 26, 2004, March 1, 2004, January 6, 2004, April 28, 2003, July 7, 2003, October 28, 2003.

Clinical Manifestation of HIV/AIDS. Phase 1 Medical Students, Mechanisms of Disease Block, 2002, 2003, 2004.

HIV and AIDS. Phase I Medical Students, ID Block, November 13, 2001.

Antibiotics for Medical Students. Phase I Medical Students, ID Block, November 5, 2001.

Rational Use of Antibiotics. Phase I Medical Students, ID Block, November 9, 1999.

International Medicine in Africa. Medical Student International Medicine Club, September 30, 1999.

Vaccines and Antibiotics. Six 3-hour presentations each year, 3rd year/Phase II students, 1993-98.

HIV/AIDS. Phase II Infectious Diseases Block lecturer, Fall 1997, 1998, 1999.

Incorporating HIV into a primary care practice. American Medical Student Association, Albuquerque, New Mexico, October 1996.

Biology 296: AIDS and the Biology of HIV, TVI-UNM Biology Department, Spring Semester 1996-1999. Co-founded course with Technical Vocational Institute (TVI) and UNM professors. Attended all 26 of the 1¼ hour class sessions and was responsible for writing and proctoring exams and the following presentations:

1. Clinical aspects of HIV/AIDS
(Two 1 1/4 hour lectures)
2. Treatment of HIV
(Two 1 1/4 hour lectures)
3. Worldwide, national and local epidemiology
(Two 1 1/4 hour lecture)
4. Prevention of HIV transmission
5. HIV infected guest speakers (moderator)
(2 1 1/4 hour presentations)
6. HIV related videos, class discussion.
7. AIDS in Africa (1 ¼ hour lecture)
8. History of HIV (1 ¼ hour lecture)

Parasitology of the Southwest pertaining to HIV patients. Albuquerque Technical Vocational Institute, Fall Semesters 1997, 1995, 1994, 1993.

HIV epidemiology, natural history, early care. AIDS Block, December 1993.

Magic Johnson and AIDS. UNM Journalism Class Interview, November 27, 1991.

UNM Noon Conferences

Vaccines, June 29, 2004.

Cystic Fibrosis, June 1, 2004.

Antibiotics, April 13, 2004.

Ethics Committee Presentation: Provision of Home IV Antibiotics to Injection Drug Users, September 26, 2003.

Vaccines, May 20 and 22, 2003.

Osteomyelitis: Round table discussion with Orthopedics and Infectious Diseases, University Hospital, February 19, 2003.

Antibiotics Update 2002, January 9 and 10, 2002.

Vaccines and HIV Prophylaxis, December 11 and 12, 2001.

Vaccines for Adults and Prophylaxis for HIV Patients, October 25 & 27, 1999.

Vaccines for Adults and Prophylaxis for HIV Patients, September 28, 1998.

Infectious Diseases Medical Knowledge Self Assessment Program Review, June 22 & 23, 1998.

Vaccines for Adults and HIV Prophylaxis, November 10 & 12, 1997.

Antibiotics, July 21, 1997.

Highly Active Antiretroviral Therapy, July 9, 1997.

Vaccinations. November 6 & 7, 1996.

Antibiotics. October 17 & 21, 1996.

Infectious Disease Board Review. January 16 & 17, 1996.

Vaccinations, November 16 & 20, 1995.

Antibiotics. October 26 & 30, 1995.

Vaccinations. September 14 & 15, 1994.

Early Care of HIV Patients. July 1993.

Common Infectious Disease Problems. July 1993.

Antibiotics. May 18 & 19, 1993.

Vaccines. March 16 & 17, 1993.

Early Care of the HIV Patient. April 8, 1992.

HIV Patients in Urgent Care -- Sorting HIV from Non-HIV Illnesses. March 4 & 31, 1992.

Parvo B19, Malaria, Schistosomiasis, Lyme Disease -- Board Review, March 1992.

The Game of Pneumonia. December 17 & 18, 1991.

Antibiotics. September 28 & October 2, 2000.

UNM Clinical Pathology Conferences

49 year-old with TB, untreated for 2 years. October 9, 1998.

19 year-old girl with aseptic meningitis. Presentation with Bob Parsons, M.D., April 18, 1997.

Middle aged patient with lung abscess, positive stains for AFB.
Presentation with Bud Hodgins, M.D. Estimated date 1996.

50 year-old man with new onset AIDS and PCP. Presentation with Doug
Mapel, M.D. October 18, 1996.

49 year-old woman with back pain. Discussion of lung cancer. February 3,
1995.

17 year-old male with Neisseria Meningitis. May 20, 1994.

Middle-aged woman with Chronic Fatigue. September 1993.

Alcoholic with fever and thrombocytopenia. Discussion of relapsing fever
(Borrelia) and other infectious diseases associated with hematologic
findings. July 1992.

72 year-old male with fever, abdominal pain and hematuria.
Discussion of Clostridial sepsis. May 10, 1991.

Elderly man with Enterococcal sepsis. October 4, 1991.

Middle-aged man with adenopathy from Salmonella. September 27, 1991.

Young woman with fever, headache and abdominal pain. Discussion on
Typhoid Fever. November 19, 1990.

UNM General Medicine Clinic Presentations

Screening for Colon Cancer. November 7, 1996.

Immunizations. January 16 & 17, 1992.

Death, Dying, Bereavement, Living Wills. September 1991.

Care of the Health HIV patient. September 1991.

UNM Resident Morning Report Invited Presentations

Tuberculosis. April 14, 1998.

Tuberculosis. March 11, 1996.

Rheumatic Fever. February 10, 1995.

Rhodococcus. May 11, 1993.

Salvage Therapy in Pneumocystis Pneumonia. April 22, 1992.

Coronary Artery Disease in an HIV patient. March 2, 1992.

Toxic Shock. October 2, 1991.

Endocarditis and Lung Abscess in an HIV patient. October 1991.

Salmonella Sepsis in HIV. July 9, 1991.

UNM Medical Knowledge Self Assessment Program (MKSAP) Reviews

Infectious Diseases. March 18, 1997.

Human Immunodeficiency Virus. January 7, 1997.

Infectious Diseases. March 4, 1996.
Human Immunodeficiency Virus. February 21, 1996.
Infectious Diseases. February 7, 1996.
Infectious Diseases. January 11, 1995.
Human Immunodeficiency Virus. December 14, 1994.
Infectious Diseases, yearly review, 1990-1993.

UNM Infectious Diseases Fellow Conferences

Infectious Diseases Board Review, monthly 2012-2013
Journal Club presentation, April 8, 2004.
Journal Club presentation, September 25, 2003.
Adult Cystic Fibrosis, February 20, 2003.
Journal Club, September 12, 2002.
Infectious Diseases Board Review (fellows), weekly, January, 2002-2005.
Penicillins and Cephalosporins (Mandell Review) April 13, 2000.
Immunizations (Mandell Review), January 2000.
HIV and Pregnancy in the Era of Highly Active Antiretroviral Therapy.
March 4, 1999.
Anti-Infective Therapy: Macrolides, Clindamycin, Vancomycin and
Teicoplanin (Mandell Review), January 7, 1999.
Immunization (Mandell Review), March 30, 1998.
Acquired Immunodeficiency Syndrome (Mandell Review), December 15,
1997.
Anthrax and other weapons of mass destruction. December 11, 1997.
Upper Respiratory Infections, February 18, 1997.
Anti-infective Therapy. November 4, 1996.
American Foundation for AIDS Research Conference Review, March 6,
1996.
HIV Risk Behavior in Women Obtaining Abortions. February 12, 1992.
Antibiotic Review. July 10, 1991.
Women, HIV-infection and Abortion. February 22, 1991.

UNM Pulmonary Division Fellow Conferences

Fungal Infections in the ICU. March 31 and May 5, 1993.

**New Mexico Community
Service/Lectures:**

Breathe Easy 5K Run in honor of J. Patrick Garcia in support of
Pulmonary Hypertension Research, November 9, 2013.

Cystic Fibrosis (Bike) Ride for Cure, Rio Rancho, September 30, 2012

Breathe Easy 5K Run in honor of J. Patrick Garcia in Support of Pulmonary
Hypertension Research, November 3, 2012.

New Research in Cystic Fibrosis, CF Family Day, Carrie Tingly Hospital,
Albuquerque, April 26, 2003.

HIV 101 and all the HIV Medications for HIV Case Managers, New Mexico AIDS Services, Albuquerque, November 29, 2001.

Overlook Water Cooperative, Vice President 1/2000-12/2001. Providing water services for Placitas subdivision.

The truth about HIV: Facts you need to protect yourself and your family. Mini-Medical School, Office of Continuing Medical Education, Albuquerque. February 8, 2000.

Health Care for the Homeless, volunteer clinic physician, Albuquerque. August 13, 1999.

AIDS Crisis in India, assisted Los Alamos Labs physicist gather and present information about AIDS to communities in India, Summer 1999.

Welsh Seminars, Steering Committee member for The Sequoias Retirement Community in lectures series on English Literature, San Francisco. July 1999-July 2000.

What Does The Future Hold?: A Medical Update. Information for HIV Patients. New Mexico AIDS Services, Albuquerque. August 19, 1998.

Antiretroviral Therapy. NetWorking New Mexico, New Mexico HIV Community Retreat Spring '98. Roswell, New Mexico.

Medical Information Update—Information for HIV Patients. New Mexico AIDS Services. Monte Vista Christian Church, Albuquerque. May 20, 1998.

AIDS. Rotary Club. Albuquerque, New Mexico. May 7, 1998.

Reaching for the Stars. The University of New Mexico Star Scholar Reception. Silver City, New Mexico. April 21, 1998.

Highly Active Antiretroviral Therapy. Emmanuel Metropolitan Community Church's HIV/AIDS Ministry. March 22, 1998.

Phlebotomy and counseling services, New Mexico State Department of Health. Project to determine seroprevalence of gay men attending a gay bar in Santa Fe, New Mexico, May 30, 1997.

TVI Freshman Biology Summer Scholarship Program. Presentation on becoming and being a physician. May 28, 1997.

Health Resource Center of New Mexico, Inc. Rural Provider Education Social Marketing Program. Consultant, August 9 & 10, 1997, Santa Fe, New Mexico.

Living with HIV. Partners in Care Grant, 2-hour evening presentation every 8 weeks 1990-1996.

Volunteer Physician, Hospital Centrale, Abidjan, Ivory Coast, July 1996.

University of New Mexico Speakers Bureau, 1996-2005.

HIV/AIDS. Presentation for Sandia High School, Albuquerque, New Mexico. July 13, 1995.

Interviewee on KOAT Channel 7 regarding HIV testing of pregnant women, February 1995.

Phlebotomy and counseling Services, New Mexico Department of Public Health Project to establish HIV, Hepatitis B and Hepatitis C Seroprevalence in injection drug users, May 28, 31 and June 7, 1994.

AIDS in Our Community. Keynote Address, 11th International AIDS Candlelight Memorial and Mobilization, May 22, 1994.

HIV/AIDS. Three 1-hour presentations for Van Buren Middle School students, Albuquerque, New Mexico. May 19, 1994.

Women with HIV. 1994 Statewide HIV Symposium, Angel Fire, New Mexico, May 1994.

Epidemiology and Overview of Women with HIV. Juntas en la Lucha—Together in the Struggle, AIDS Education and Training Center, March 24, 1994.

HIV/AIDS. Presentation for Sandia Preparatory School, Albuquerque, New Mexico. December 1993.

Interviewee on Public Television, MacNeil-Lehrer News Hour for story on Hantavirus outbreak, June 1993.

Interviewee on Public Television, 30 minute Live Call-in Program, Amarillo, Texas answering questions about Hantavirus case in Texas, Summer 1993.

Interviewee on Local Television News Programs about Hantavirus, several, Spring and Summer 1993.

Interviewee on “How’d They Do That?” National television show on solving the Hantavirus mystery, Summer 1993.

Viral Hepatitis. KOAT Health Issues presented by UNM. Prepared written material, February 1992.

Supervision of Science Fair Microbiology Project for Jefferson Elementary School Student (Jacob Wootton) November 1991 and March 1992.

Guest on KOAT 30 minute Live Call-in Program, Host Barry Ramo, answering questions about AIDS after announcement Magic Johnson was infected, November 14, 1991.

Scholarly Achievements:

Books Authored or Co-authored:

Allen, S. *Africa Letters*: a collection of letters written from Kenya, Tanzania and Ivory Coast in 1995-96. Redactors' Press, San Francisco, 2005.

Original Research or Scholarly Articles in Refereed Journals:

Liou TG, Jensen JL, **Allen SE**, Brayshaw SJ, Brown MA, Chatfield B, Koenig J, McDonald C, Packer KA, Peet K, Radford P, Reineke LM, Otsuka K, Wagener JS, Young D, Marshall BC. [Improving performance in the detection and management of cystic fibrosis-related diabetes in the Mountain West Cystic Fibrosis Consortium](#). BMJ Open **Diabetes** Res Care. 2016 Apr 29;4(1):e000183. doi: 10.1136/bmjdr-2015-000183. eCollection 2016.

Feldman EM, Ellsworth W, Yuksel E, **Allen S**. Mycobacterium abscessus infection after breast augmentation: a case of contaminated implants? J Plastic Reconstr Aesthet Surg. 62(9); e330-2.

Aboutalebi A, Shen A, Katta R, **Allen SE**, Primary Cutaneous Infection by Mycobacterium avium: A Case Report and Literature Review. Cutis. 2012;89: 175-179.

Ketai L, Williamson M, Telepak R, Levy H, Koster F, Nolte K and **Allen S**. Hantavirus Pulmonary Syndrome: Radiographic Findings in 16 Patients. Radiology 1994; 191:665-668

Palmer DL, Hjelle BL, Wiley CA, **Allen S**, et al. HIV-1 Infection Despite Immediate Combination Antiviral Therapy After Infusion of Contaminated White Cells. The American Journal of Medicine, September 1994; 97:289-295.

Hjelle B, Mills R, Swenson S, Mertz G, Key C, **Allen S**. Incidence of Hairy Cell Leukemia, Mycosis, Fungoides, and Chronic Lymphocytic Leukemia in First Known HTLV-II Endemic Population. Journal of Infectious Diseases 1991; 163 (3):435-440.

**Review Articles/Articles Appearing
as Chapters in Edited Volumes:**

Allen S. Prevention of Infectious Diseases by Active and Passive Immunization. Medicine: A Primary Care Approach. Rubin R, et al, eds. WB Saunders Co. 1996.

Quenzer R and **Allen S.** Infections in the Critically Ill. Current Critical Care Diagnosis & Treatment. Bongard FS and Sue DY, Eds. Appelton & Lang, Norwalk, Connecticut, 1994.

**Other Writings and Scholarly
Products:**

Gallant JE and **Allen S**, Editors, Improving Treatment Strategies for Antiretroviral Therapy. Presentations in Focus, September 2003.

Rockstroh J and **Allen S**, Editors, Simplifying Regimens and Reducing Toxicities in the Highly Active Antiretroviral Therapy (HAART) Era. Presentations in Focus, October 2003.

Pai A and **Allen S**, Voriconazole Inhibition of Tacrolimus Metabolism (Letter). Clinical Infectious Diseases, 2003;36(8):1089 - 91.

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Duchin J, Koster F, Peters C, et al and The Hantavirus Study Group. Hantavirus Pulmonary Syndrome: A clinical description of 17 patients with a newly recognized disease. NEJM 1994; 330:949-55.

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Submitted Works:

Allen S, Doherty P, and Samuel M. Risk Factors for and Seroprevalence of Human Immunodeficiency, Hepatitis B and Hepatitis C Viruses in Hispanic, Native American and Non-Hispanic White Women Seeking Abortion in New Mexico.

**Invited/Refereed Abstracts/
Presentations
at Professional Meetings:**

Chapman LE, Mertz G, Khan AS, Hart DC, Peters CJ, Koster F, Ksiazek TG, Rollin PE, Wilson LJ, Baum KF, Pavia AT, Christenson JC, **Allen S**, Rubin PJ, Goade D and the Ribavirin Study Group. Open Label Intravenous Ribavirin for Hantavirus Pulmonary Syndrome. Abstract H111. Abstracts of the 34th Interscience Conference on Antimicrobial Agents and Chemotherapy. October, 1994.

Thornton K, **Allen S**, Ulibarri-Keller N. Women with HIV in New Mexico (Abstract presentation). American College of Physicians New Mexico Scientific Meeting, 1993.

**Contributed (unrefereed) Abstracts
and/or Oral Presentations at
Professional Meetings:**

Allen S, Wootton C, Doherty P, Levy A, Voorhees R and Palmer D. HIV Risk in Hispanic and Native American Women Presenting for Abortion (poster). American College of Physicians New Mexico Scientific Meeting, 1992.

Jutila C, Gurule F, **Allen S**, Croke R, Shively B. Echocardiographic Predictors of Survival in Electromechanical Dissociation (Abstract presentation). American College of Physicians New Mexico Scientific Meeting, 1988.

Grant and Contract Funding:

University of New Mexico

HRRC 09-413, "Sample Acquisition Study to Evaluate the nanoMR Pathogen Capture System." PI: Steve Young, PhD. Have assisted in arranging for a portion of sample acquisition for patients in the Outpatient Treatment Center.

HRRC 03-326, "Epidemiologic Study of Cystic Fibrosis: A multicenter, longitudinal follow-up study of patients with Cystic

Fibrosis for monitoring pulmonary function, pulmonary exacerbations, and the safety of long-term treatment with Pulmozyme (dornase alfa)," ~\$3,000-\$5,000/each year, 2003-2005. Funded by Genentech. Principal Investigator: Sarah Allen, MD.

HRRC 03-287, "Improving Performance in the Detection and Management of Cystic Fibrosis Related Diabetes." \$7,500 each year for three years. Funded by University of Utah Health Sciences Center. Principal Investigator: Sarah Allen, MD.

HRRC 03-418: "The effect of calcium supplementation on the steady-state pharmacokinetics of oral once daily 750 mg doses of levofloxacin in adult cystic fibrosis patients." \$10,000 for project period 2003-2004. Principal Investigator: Amit Pai, PhD; Co-Investigator: Sarah Allen, MD.

HRRC 02-537, "Cystic Fibrosis Registry" Awarded 2003 and 2004, \$6,000/year for the Adult CF Clinic for providing data on 53 CF patients we care for. Funded by the Cystic Fibrosis Foundation. Principal Investigator, Elizabeth Perket, MD.

Past Grant/Contract Funding:

University of New Mexico

Research Allocation Grant, Awarded July 1, 1993, \$7500, Risk Factors for and Seroprevalence of Human Immunodeficiency, Hepatitis B and Hepatitis C Viruses in Hispanic, Native American and Non-Hispanic White Women Seeking Abortion in New Mexico

Vulnerability and Informed Consent in Clinical Research. Laura Roberts, M.D., Principal Investigator. National Institutes of Health.

Administrative Positions:

New Mexico (2012 – present):

Antibiotic Subcommittee, University Hospital, Albuquerque, Meghan Brett, Chair, 2012-2015.

Director, Outpatient Treatment Center (OTC), UNMH, 8/2012-11/2015

Director, Outpatient Parenteral Antibiotic Treatment Center (OPAT), UNMH, 8/2012-11/2015

Texas (2005 – 2012):

Antibiotic Subcommittee, The Methodist Hospital, Texas Medical Center, Houston, Texas, 8/2007-5/2012.

New Mexico (1986 – 2012):

Co-Chair, Infectious Diseases Society of New Mexico Quarterly Dinner Meetings, 1999-2000.

Co-Chair and Moderator, Infectious Diseases Pot Pourri Conference 2000, 2001, 2002, 2003, 2004.

Narrative Review Board, Teacher and Education Development, Stewart Mennin, chair, 1999

Phase I ID Block co-director with Roger Radloff, 1998-2000.

Health Management Alliance, Primary Care Clinician, District #1, 1997-2005.

American College of Physicians, Program Committee Member, 1995 New Mexico Scientific Meeting, Bill Reed, Chair.

American College of Physicians, Program Committee Member, Annual Physician-Legislature Meeting. November 19, 1995.

HIV General Medicine Conference, Conference Coordinator and Commentator, July 1994.

HIV General Medicine Conference, Conference Coordinator and Commentator, January 1994.

Hantavirus Symposium Conference Committee Coordinator, August 1993.

HIV General Medicine Conference, Conference Coordinator and Commentator, July 1993.

HIV General Medicine Conference, Conference Coordinator and Commentator, January 1993.

HIV General Medicine Conference, Conference Coordinator and Commentator, July 1992.

American College of Physicians, Program Committee Member, 1991 New Mexico Scientific Meeting.

University of New Mexico, SOM, HSC Department Committees

and Administrative Duties:

Promotions Committee, January 2004-2005. Chair Terry Crowe, PhD

Search Committee for 5ACC Medicine Clinic Manager, January 2004. Chair David Gonzales, MD

Pharmaceuticals and Therapeutics Committee, member September 1999-2005. Chair: Corey Ford, MD

Pharmaceuticals and Therapeutics Antibiotic Subcommittee, member: July 1991 - January 1992 and September 1999-2005. Chair: Gary Overturf, MD.

Pharmaceuticals and Therapeutics Adverse Drug Reactions Subcommittee, Founder and Chair: December 1999-2000.

Risk Management, Review of HIV related case pending litigation, September, 1998

University Hospital Infection Control, member 1991-2002.

Current Chair: Susan Kellie, Past Committee Chairs: Fred Koster, M.D. and Greg Mertz, M.D., Gail Scully, M.D.

Clinic Operation Team, 5th Floor Medicine Clinics, member 1998. Committee Chair: Sanjeev Arora, M.D.

Department of Medicine Clinical Provider Search Committee, Infectious Diseases Division, Chair: Greg Mertz, M.D., 1997-98

Department of Medicine Intern Selection Committee, 1995, 1992.

Department of Communication and Journalism, Thesis Committee: John Mandes, Master's Candidate. HIV and Journalism. Prospectus Defense, September 1994; Thesis Defense, April 1995.

Department of Medicine Clinical Provider Search Committee Infectious Diseases Division, Chair: Darwin Palmer, M.D., 1993-94.

New Mexico AIDS Services, Project for Women, 1993-94.

University of New Mexico School of Medicine New Curriculum Assessment Task Force, 1992.

Hobbies: Triathlons

Full Ironman 140.6, Boulder, Colorado, August 2, 2015

Full Ironman 140.6, Cabo, Mexico, March 30, 2014

Half Ironman 70.3, Austin, Texas, October 27, 2013

WILLIAM S. FREEMAN (SBN 82002)
wfreeman@aclunc.org
SEAN RIORDAN (SBN 255752)
sriordan@aclunc.org
ANGÉLICA SALCÉDA (SBN 296152)
asalceda@aclunc.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN
CALIFORNIA
39 Drumm Street
San Francisco, CA 94111
Telephone: (415) 621-2493
Facsimile: (415) 255-8437

Attorneys for Petitioners-Plaintiffs
Additional Counsel Listed on Following Page

MANOHAR RAJU (SBN 193771)
Public Defender
MATT GONZALEZ (SBN 153486)
Chief Attorney
GENNA ELLIS BEIER (CA SBN 300505)
genna.beier@sfgov.org
EMILOU H. MACLEAN (CA SBN 319071)
emilou.maclean@sfgov.org
FRANCISCO UGARTE (CA SBN 241710)
francisco.ugarte@sfgov.org
OFFICE OF THE PUBLIC DEFENDER
SAN FRANCISCO
555 Seventh Street
San Francisco, CA 94103
Direct: (415) 553-9319
Facsimile: (415) 553-9810

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ANGEL DE JESUS ZEPEDA RIVAS,
BRENDA RUBI RUIZ TOVAR,
LAWRENCE KURIA 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. 3:20-CV-02731-VC

**DECLARATION OF ROBERT B.
GREIFINGER, M.D. IN SUPPORT OF
PETITIONERS-PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

BREE BERNWANGER* (NY SBN 5036397)
bbernwanger@lccrsf.org
HAYDEN RODARTE (SBN 329432)
hrodarte@lccrsf.org
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS OF
SAN FRANCISCO BAY AREA
131 Steuart St #400
San Francisco, CA 94105
Telephone: (415) 814-7631

JUDAH LAKIN (SBN 307740)
judah@lakinwille.com
AMALIA WILLE (SBN 293342)
amalia@lakinwille.com
LAKIN & WILLE LLP
1939 Harrison Street, Suite 420
Oakland, CA 94612
Telephone: (510) 379-9216
Facsimile: (510) 379-9219

JORDAN WELLS (SBN 326491)
jwells@aclusocal.org
STEPHANIE PADILLA (SBN 321568)
spadilla@aclusocal.org
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF SOUTHERN CALIFORNIA
1313 West Eighth Street
Los Angeles, CA 90017
Telephone: (213) 977-9500
Facsimile: (213) 977-5297

MARTIN S. SCHENKER (SBN 109828)
mschenker@cooley.com
COOLEY LLP
101 California Street, 5th Floor
San Francisco, CA 94111
Telephone: (415) 693-2000
Facsimile: (415) 693-2222

TIMOTHY W. COOK* (Mass. BBO 688688)
tcook@cooley.com
FRANCISCO M. UNGER* (Mass. BBO 698807)
funger@cooley.com
COOLEY LLP
500 Boylston Street
Boston, MA 02116
Telephone: (617) 937-2300
Facsimile: (617) 937-2400

Attorneys for Petitioners-Plaintiffs
**Admitted Pro Hac Vice*

Second Supplemental Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have 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.
2. I provided two earlier declarations in this case, dated April 19 and April 26, 2020, and now provide this second supplemental declaration after reviewing materials provided by the Defendants to Plaintiffs and the Court, and new fact declarations from class members, describing the current conditions of detention at Mesa Verde Detention Center and Yuba County Jail.
3. In addition to the documents I reviewed previously, I have reviewed:
 - a Defendants' Objections and Responses to Plaintiffs' Interrogatories, dated May 8, May 12, May 19, May 20, and May 21, 2020;
 - b Defendants' Updated Supplemental Declaration of ICE Assistant Field Office Director Alexander Pham, dated May 11, 2020, filed in *Singh v. Barr*, No. 20-cv-02346-VKD (U.S.D.C., N.D. Cal.);
 - c Email of Shiwon Choe to Plaintiffs, May 19, 2020 10:14 am re: *Zepeda Rivas v. Jennings*, No. 3:20-cv-02731 (regarding the number of individuals in each housing unit at Yuba);
 - d Plaintiffs' Declarations of Fermin Trujillo Lopez, Gilberto Pablo Perez, Jose Mejia Rosas, Juan Aguilar Castaneda, Livia Pinheiro, Maynor Oxlaj Siguantay, Pravindar Singh, Arias Marroquin, Asif Massom Qazi, and Aylaliyah Burru;
 - e Visual images of the dorms at Mesa Verde and Yuba County Jail prepared by Scott Hilton based on information supplied by Defendants in their responses to Plaintiffs' interrogatories (and incorporated where specified in this declaration);
 - f Photographs of Mesa Verde and Yuba, incorporated herein with references, authenticated by declarants as consistent with current conditions of the detention centers, and previously presented in (1) *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (photographs amended to Dkt. 220, Declaration of Pablo Stewart MD in support of Plaintiffs' Motion to Enforce Consent Decree and for Further Remedial Orders); (2) *Lyon v. ICE*, Case No. 3:13-cv-05878 (E.D. Cal.) (photographs amended to Dkt. 119-20, Declaration of Carl Takei

in Support of Plaintiffs’ Motion for Summary Adjudication); and (3) ACLU SoCal, “Lawsuits Demand Halt in ICE Transfers and Reductions in Jail and Juvenile Hall Populations,” Apr. 24, 2020, available at <https://www.aclusocal.org/en/press-releases/aclu-sues-governor-ca-supreme-court-over-pandemic-conditions>.

4. From the evidence I have reviewed, it is my opinion that ICE continues to fail to meaningfully respond to the COVID-19 pandemic, jeopardizing the health and safety of those detained in ICE custody at Mesa Verde and Yuba County Jail, as well as the staff and visitors of the facilities and the surrounding communities.

IMPORTANCE OF SOCIAL DISTANCING

5. As I have outlined previously, social distancing is the most critical tool to limit the individual and community risk of COVID infection. This is because the greatest mechanism for COVID-19 transmission is through droplet transmission. When someone infected with COVID-19 coughs, sneezes, or talks, small and often imperceptible droplets travel through the air into the noses and mouths, and ultimately respiratory tracts, of people in the vicinity. People may also be infected when droplets land on a surface – such as a table, doorknob or toilet seat – and a person touches that surface and then touches their nose or mouth.
6. The COVID-19 virus is believed to be more durable than other some other comparable viruses, and able to remain infectious for a longer period of time. COVID-19 may survive and be infectious in the air or on a surface for hours or days.
7. The kind of surface also affects how long the virus can survive. In studies, the virus has been found to be detectable and potentially infectious for 24 hours on cardboard, and even longer on plastic and stainless steel—where it can survive for up to 72 hours though at diminishing concentrations. The “half-life” of the virus (or the length of time for its concentration to halve) was nearly four hours on cardboard, nearly 6 hours on steel, and nearly 7 hours on plastic.
8. Social distancing is considered a nonpharmaceutical intervention (NPI) – in the same class as hand washing and face coverings – of heightened importance when biologic or pharmaceutical interventions (such as a vaccine or medications) are unavailable and not expected for some time. Social distancing is valuable to protect an individual against infection and moreover is critically important to protect a community against pandemic spread. Effective social distancing can reduce the attack rate (or percentage of people who become infected in a given time period) and number of deaths and limit the strain on scarce health and other public resources.

9. In 2007, the CDC recommended social distancing as a critical tool to respond to respiratory viruses in the absence of a vaccine,¹ and reaffirmed this in the agency's 2017 pre-pandemic strategy guidance.² The importance of social distancing has become more recognized over the past 15 years in pandemic preparedness. This is a result of modeling exercises as well as epidemiological analyses of the effect of social distancing on disease transmission. Two groundbreaking studies of the 1918 flu showed that cities that acted quickly to force social distancing (i.e., school closures, the cancellation of gatherings and mandatory quarantines) at the time had significantly lower mortality and peak death rates (in one of the studies, 20% decreased cumulative mortality and 50% of the peak death rates) than those that acted more slowly.³
10. Social distancing is sometimes considered shorthand for maintaining six feet of distance at all times from other people. However, social distancing first and foremost incorporates the idea of avoiding prolonged contact in confined spaces, i.e., congregate settings and mass gatherings, wherever possible. Shelter-in-place and lockdown orders or recommendations are more protective—for individuals and communities—than avoiding exposure at six feet of distance. The six-foot social distancing recommendation is primarily aimed at reducing exposure in infrequent interactions and outdoor settings, with the priority being to limit even these interactions as much as possible. The six-foot recommendation also effectively works to limit the total number of people in a confined space (like a grocery store, for example) at a given time; this is inherently more protective.
11. Six feet of distance is not a hard line that guarantees protection, but a guideline to help limit the spread of COVID-19 by droplet transmission. The recommendation that, where interaction is necessary, maintaining a minimum of six feet of distance from others is derived from the perception that droplet particles of greater than 5 microns typically (due to their size and weight) fall to the ground where they are no longer infectious within six feet. However, large droplets are capable of being carried for more than six feet, particularly with the force of a cough or a sneeze. Droplets propelled from a cough have been found to travel up to 16 feet and from a sneeze up to 27 feet, and may carry the virus with them for that distance.⁴ One review found eight of ten studies on horizontal droplet distance showed droplets traveling more than six feet and recommended greater distancing particularly in high-risk

¹ CDC, Interim pre-pandemic planning guidance: community strategy for pandemic influenza mitigation in the United States : early, targeted, layered use of nonpharmaceutical interventions," Feb. 2007, at <https://stacks.cdc.gov/view/cdc/11425>, at 9.

² CDC, "Community Mitigation Guidelines to Prevent Pandemic Influenza—United States, 2017," Apr. 21, 2017, at <https://stacks.cdc.gov/view/cdc/45220>.

³ See, e.g., Richard Hatchett et al., "Public Health Interventions and Epidemic Intensity During the 1918 Influenza Pandemic," Proceedings of the National Academies of Sciences of the United States, May 1, 2007, at <https://www.pnas.org/content/pnas/104/18/7582.full.pdf>; Howard Markel, et al., "Nonpharmaceutical Interventions Implemented by US Cities During the 1918-1919 Influenza Pandemic," JAMA, Aug. 8, 2007, at <https://jamanetwork.com/journals/jama/fullarticle/208354>.

⁴ Lydia Bourouiba, "Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19," JAMA, Mar. 26, 2020, at <https://jamanetwork.com/journals/jama/fullarticle/2763852>.

environments.⁵ This review of the literature found a maximum recorded distance of approximately 26 feet.

12. There is growing evidence that aerosol transmission (of smaller particles less than 5 microns which may survive, and travel, in the air for longer and further) is also possible. The possibility of airborne transmission has been considered because “viral shedding” (or contamination of the virus) has been found in the air in rooms where patients were infected with COVID-19.⁶ Indeed, aerosol transmission was important in 2002-2003 in certain SARS-related “superspreader events,” where many people were infected in a single incident. If aerosolized (as opposed to the larger airborne droplet) transmission is a significant form of transmission for COVID-19, six feet of distance is even less protective as tiny aerosolized virus particles are able to remain in the air for longer. For small aerosolized particles, air currents can carry the virus more than 20 feet. However, as they are smaller and may disperse over time (even if they take longer to fall and lose their capacity for infectiousness), the risk of infection still likely decreases with growing distance.
13. Even assuming that the primary means of transmission is via the larger airborne droplets, the six-foot social distancing framework is insufficient for sleeping in a congregate setting, such as a detention facility. The risk of infection is particularly acute in crowded spaces where people remain for a prolonged period of time. The risk is even more acute in poorly-ventilated indoor areas. The basis for the increased risk of transmission for congregate settings over a prolonged period is: a) if multiple people are infected, there can be a compounding of airborne virus particles, increasing the risk of transmission, and b) in a confined space, the longer the contact time, the larger the risk of inhaling a larger “dose” of the virus.
14. It is for these reasons that I conclude that reduced population in congregate settings is the single most important means of reducing the risk of transmission to individuals in these settings. The second most important means of reducing the risk of infection in congregate settings, such as a detention facility, is ensuring a minimum of ten feet between beds for sleeping in a congregate setting and six feet for all other interactions (such as while standing in line, eating, or passing by other individuals). The necessity of individuals getting in and out of bed alone necessitates that bed spacing be greater than six feet in order to avoid being regularly within six feet of others sleeping in

⁵ Prateek Bahl et al., “Airborne or Droplet Precautions for Health Workers Treating COVID-19?” (prepublication), at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7184471/pdf/jiaa189.pdf> (“More recent studies have shown the extent of droplet spread to be greater than 2 m ($\approx$ 6 ft), and that infection risk exists beyond the recommended range of spatial separation.”).

⁶ Joshua Santarpia et al., “Transmission Potential of SARS-CoV-2 in Viral Shedding Observed at the University of Nebraska Medical Center,” medRxiv, Mar. 26, 2020, <https://www.medrxiv.org/content/10.1101/2020.03.23.20039446v2> (not peer-reviewed); Yuan Liu et al., “Aerodynamic Analysis of SARS-CoV-2 in Two Wuhan Hospitals,” Nature, Apr. 27, 2020, at <https://www.nature.com/articles/s41586-020-2271-3>.

neighboring beds.⁷ But more than that, the prolonged exposure—over many hours and many days with many people—makes a distance greater than six feet imperative in avoiding the rapid transmission of infection. From my review of the literature and my experience managing medical care in correctional facilities I conclude that ten feet is the bare minimum to provide a degree of protection from infection for those sleeping in congregate settings.

15. Relatedly, to reach the same degree of social distancing for beds that are situated in a line (i.e. head to foot), the distance between beds from edge to edge must be at least three feet if individuals sleep in the same direction (i.e., head to toe). This is because the bunkbeds are typically around 6.5 feet in length and an individual's head is not at the edge of the bed. To ensure ten feet of distance between the heads of detainees in neighboring beds, three feet of distance between beds arranged this way would be required.
16. I understand that Defendants have introduced staggering of sleeping arrangements at Mesa Verde, with detainees alternating between top and bottom bunks. This does little to eliminate or even reduce the risk of infection for those in neighboring bunks because droplets are heavy and fall from the air after traveling a few feet. (This is the foundation of the six-foot social distancing recommendation.) The droplets emitted by the person on an upper bunk will not merely circulate in the air but will ultimately fall to the ground—infectious as they descend—because of gravity's effect on dense respiratory droplets. Thus a person in a lower bunk will be similarly exposed to droplets from his neighbor whether the neighbor is sleeping in the lower or upper bed of the neighboring bunk.

LACK OF SOCIAL DISTANCING AT MESA VERDE AND YUBA

17. Social distancing must be guaranteed for sleeping, eating, recreation, using the restroom, and all other aspects of a detainee's day. From all of the evidence I have seen in this case, including the new declarations from Plaintiffs and Defendants and Defendants' responses to the interrogatories, there is inadequate social distancing in sleeping, eating, using the bathroom, and recreation in both facilities.

⁷ See, e.g., Masoom Dec. ¶ 6 (“When I am in bed, for example, I sometimes have to get down to go to the bathroom or do anything else. Once I step down from my bunk bed, I am within 3 feet of the person in the next bottom bunk. With this many people, proper social distancing is impossible.”) (declarant in Mesa Verde Dorm C); Garcia Montes Dec. ¶¶ 6-8 (“There is certainly not 6 feet between us—not while we sleep and certainly not when I have to get down from my bed for any reason.”); Solis Dec. ¶ 8 (“Regardless of the staggered sleeping arrangements, we have to get in and out of our beds for a number of reasons and end up being a few feet from the person in the next bunk bed. . . Every person is assigned a big plastic container, like a storage bin, to store our stuff. We usually store those containers under our bunkbed. When people need to get stuff out of their containers, they have step into the space in between the bunkbeds and pull the container out. When they do this, they are often right next to the person in the bed next to them.”).

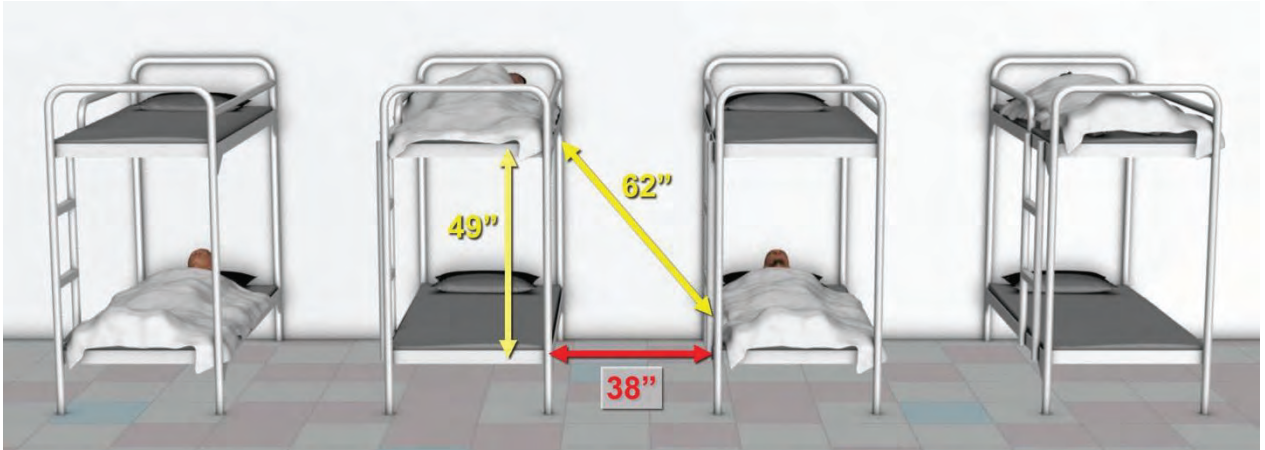
A. Sleeping

18. Based on the information provided by Defendants in this case, social distancing is impossible in the sleeping facilities used by detainees at Mesa Verde and Yuba given current structures and population levels.

1. Mesa Verde

19. The Pham Declaration affirms that the Mesa Verde capacity is at 191, or just under 50% of its capacity of 400 detainees, and that each dorm is at or below 50% capacity. This does not tell me whether there is adequate social distancing. The percentage of capacity is a meaningless figure to measure social distancing within the dorms, and for the daily lives of individuals. What matters is whether people are able to maintain distance from one another, which might be possible in some facilities at 100% of capacity and might be impossible in other facilities even at 20% of capacity. The fact that at Mesa Verde detainees sleep in large open-air dorms without barriers creates inherent risks of infection for the detainees (and the staff) even if the populations in all dorms are closer to 50 than their capacity of 100.
20. Further, at the time of my April 26 declaration, there was at least one Mesa Verde dorm that was at approximately 50% capacity. At that time I concluded that it failed to allow for adequate social distancing. Now that all of the dorms are at 50% capacity, that does not change my conclusion that even 50% capacity given the information available about the facilities is insufficient to allow for individuals to protect themselves from COVID-19 infection.
21. The Pham Declaration asserts that at Mesa Verde detainees “are or will be sleeping at least six feet apart” as detainees are alternating between top and bottom bunks in Dorms A & B, and will at some point be doing the same in Dorms C & D. (This staggered sleeping arrangement is something identified as a goal in Dorms C & D, but not something that had yet been implemented, though the declarations of class members affirm that it has happened throughout the facility.)
22. There is no evidence that this alternating sleeping arrangement does in fact mean that detainees are sleeping far enough apart to be protected from the risk of droplet transmission while they are sleeping. The median distance between beds⁸ at Mesa Verde is 38” and the upper and lower bunks are 49” from one another. Even if the relevant consideration were the diagonal straight line between the bottom bunk and the upper neighboring bunk, this would only mean a median distance of 62” between the two sleeping detainees, or just over five feet, as depicted in the diagram below. This does not even reach the six feet that the Defendants suggest, or that is recommended for occasional or transient interactions, much less a ten feet distance that would provide more meaningful protection in a congregate sleeping environment.

⁸ A median distance is used because the bunkbeds are not an equivalent distance from one another throughout the facility.

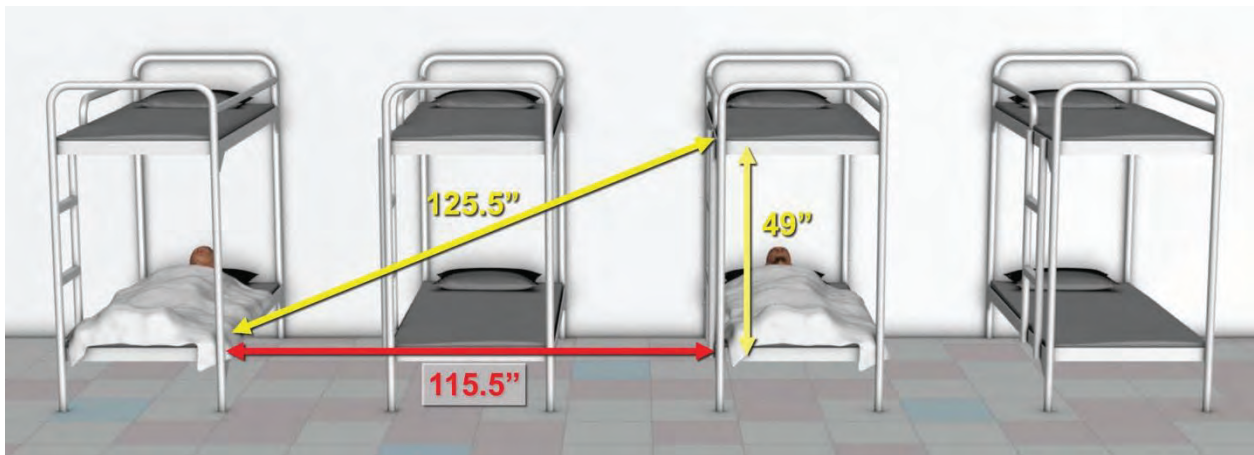


23. The assertion that this allows for adequate social distancing also ignores that individuals get in and out of bed, and quite often in a detention setting where they may spend much of their day in the dormitories. As one declarant described:

“We are not able to be socially distanced while in our bunks or while sleeping. The problem is that the distance between the beds is less than three feet. They are simply too close together, and the bunks cannot be moved. It does not matter that the people in the bunk next to me are in the top bunk while I’m in the bottom bunk. When my neighbors get down from their bunks, they are very close to me, as close as if we were going to shake hands. They are not six feet away. They have to get down from their bunks to go to the bathroom and for meals.”⁹

24. Moreover, this staggering between upper and lower bunks is not protective for the reasons outlined above in ¶ 16: gravity causes droplets to fall and they remain infectious when they fall. The appropriate consideration of distance between beds is the lateral distance, regardless of whether individuals are on the top or bottom bunks, or whether they are staggered between upper and lower bunks. The relevant distance is not “as the crow flies”—here, the diagonal between the upper bunk and the lower neighboring bunk.
25. Considering this, in Mesa Verde, the median effective distance between detainees is, in fact, only 38” (the median distance between two bunkbeds at Mesa Verde), or just over three feet. This creates a very high risk of COVID-19 infection, particularly given the prolonged periods of time that detainees spend both sleeping and more generally in these open-air dorms and on their beds.
26. To approach the minimum appropriate distance between two people sleeping in the congregate setting of the large Mesa Verde dormitories, where the bunkbeds are fixed to the floor, it would be necessary to stagger detainees sleeping not in alternating upper and lower bunks, but in alternating beds as shown in the image below.

⁹ Trujillo Dec. ¶ 6.



2. *Yuba County Jail*

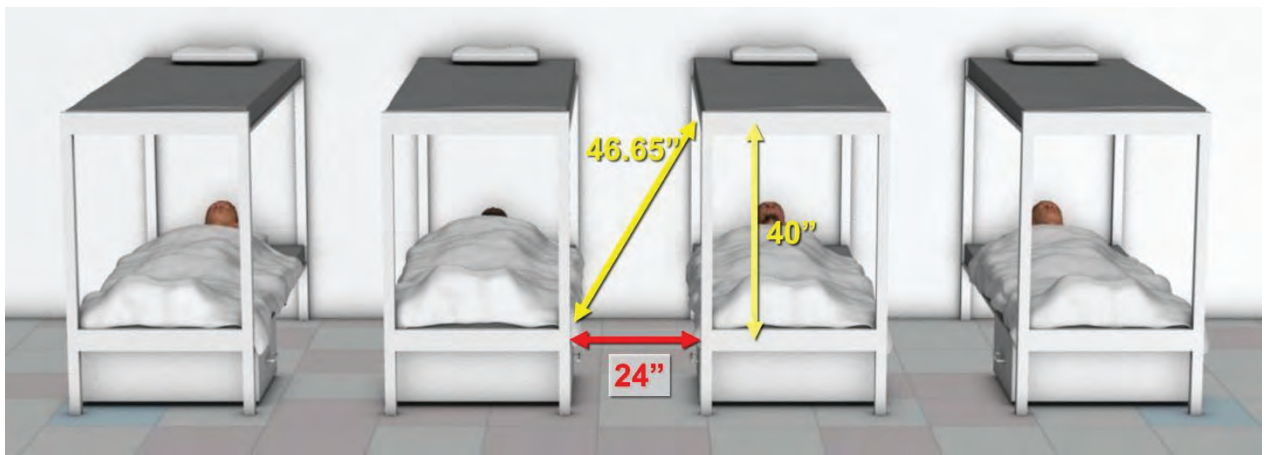
27. Unlike Mesa Verde, Yuba County Jail includes both County inmates and ICE detainees, and sometimes they are intermingled. I understand that Defendants in this case affirm that as of May 18 there are 93 ICE detainees and an unspecified number of County inmates in the facility.
28. As I described in my initial declaration in this case, relying on what was then publicly available information, Yuba County Jail has a more diverse set of sleeping arrangements than Mesa Verde. Detainees at Yuba sleep in dormitories; “linear-style open bar front cells”; or single-, double- or quadruple-celled housing. The interrogatory responses produced in this case provide more detail about the dimensions in each of the housing units and the sleeping arrangements in each.
29. Based on my review of available information, I confirm my earlier conclusion that there is inadequate social distancing for detainees at Yuba. Regardless of the type of housing, most ICE detainees at Yuba sleep in housing units where they are in bunk beds that are certainly fewer than ten feet (and even fewer than six feet) away from the other bed in the same bunk, and from the next bunk bed.
30. For the reasons identified above with regard to Mesa Verde, the percentage a facility is populated as compared to its capacity does not indicate whether there is adequate social distancing and protection from COVID-19 infection for those inside. Many of the individual housing units at Yuba—including both ICE and County detainees—are between 33 and 75 percent of capacity. This provides some useful information but does not answer the question about whether the facility as a whole, or individual housing units, are safe from COVID-19 infection for those detained.

31. Large Dormitories (B- & C- Pods and R-Dorm¹⁰):



Photo above: C-pod¹¹

32. In Yuba's larger dormitories – B-pod, C-pod and R-dorm – the bunkbeds are only two feet apart (for B- and C-pods) or three feet apart (R-dorm).



Given the proximity of the bunks to one another, unless the beds are moved, ten feet

¹⁰ B- and C-pods are large open rooms with movable bunk beds with capacity for 50 people each, with each bunk bed only two feet apart from the next side by side and three feet apart end to end. R-dorm is a female housing dorm-style housing unit with 9 bunk beds (for a maximum capacity of 18) which each bunk bed three feet apart in a total 929 square feet of space.

¹¹ Photo taken by Rosen Bien Galvan & Grunfeld LLP, available at <https://www.aclusocal.org/en/press-releases/aclu-sues-governor-ca-supreme-court-over-pandemic-conditions>, confirmed as presently accurate by Plaintiffs' class member Gilberto Pablo Perez.

of distance between two sleeping individuals in the congregate settings of Yuba's largest dormitories would only be achieved if detainees slept on every third bunk.¹² Unlike in Mesa Verde, the bunkbeds are movable within these dormitories in Yuba but it is not apparent how they could be moved within the existing space given that individuals also eat and effectively live in these dormitories during their detention.¹³

33. Class member Livia Pinheiro described the close quarters for women in R-dorm: "When I slept, if I reached out, I could definitely touch the person next to me. She was just a couple of feet away from me. It is impossible to stay six feet apart from other people with this set-up."¹⁴ Even where dormitories are well below capacity, detainees describe social distancing as an impossibility.¹⁵



*Photo:
R-dorm¹⁶*

¹² Where measurements were provided, the bunk beds are typically 6'6" long and 2'6" wide. There are some variations: bunkbeds in B- and C-pods measured 6'9" long x 2'10" wide, Q-cell 6'8" long x 2'9" wide, R-dorm 6'8" long x 2'7" wide, S-tank 6'5" long x 2'7" wide, P-tank 6'8" long, and T-tank 7' long x 2'11" wide.

¹³ I understand that on the day of my finalizing this declaration, Defendants produced a fourth supplemental response to Plaintiffs' interrogatories that identified that two dormitories – B-pod and C-pod – were reconfigured. Yuba County Jail removed five beds, spaced each bed approximately six feet apart on both sides, and is now utilizing only the lower beds on the bunkbeds. For the reasons elaborated within this declaration, this still does not respond meaningfully to the threat of COVID-19, protect detainees or staff from the likelihood of transmission, or permit adequate social distancing while sleeping in a congregate setting.

¹⁴ Pinheiro Dec. ¶¶ 6-7.

¹⁵ Pablo Dec. ¶ 5 ("There was no way to stay six feet apart in B Pod. There were too many people there. All of the top bunks were empty, but the bottom ones were almost full. There were people sleeping on both sides of me. I was surrounded by beds to my left, right, at my feet and head. If I stretched my arm out to the left, I could touch the person who slept there.").

¹⁶ DSC 00114 from Takei Declaration, photo taken Oct. 13, 2015 confirmed as presently accurate by Plaintiffs' class member Maria Andreas Salgado.

34. Open Bar-Front Dormitories (G- Through L- “Tanks”)



Photo: sleeping area in one of the “tanks” in the “Old Jail”¹⁷



Photo: I-tank¹⁸

¹⁷ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Pablo Stewart MD in support of Plaintiffs’ Motion to Enforce Consent Decree and for Further Remedial Orders in *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (Dkt. 220 at 185, Sept. 1, 2017).

¹⁸ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Carl Takei in Support of Plaintiffs’ Motion for Summary Adjudication in *Lyon v. ICE*, Case No. 3:13-cv-05878 (E.D. Cal.) (Dkt. 197-15 at 4 (DSC 00105), Apr. 7, 2016 & Dkt. 119-20, Dec. 18, 2015 (“DSC 0105 depicts . . . the view from the table to the living area” of “Yuba – Unit I”)).

G through L “tanks” in the “Old Jail” at Yuba 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. (See photo below.)

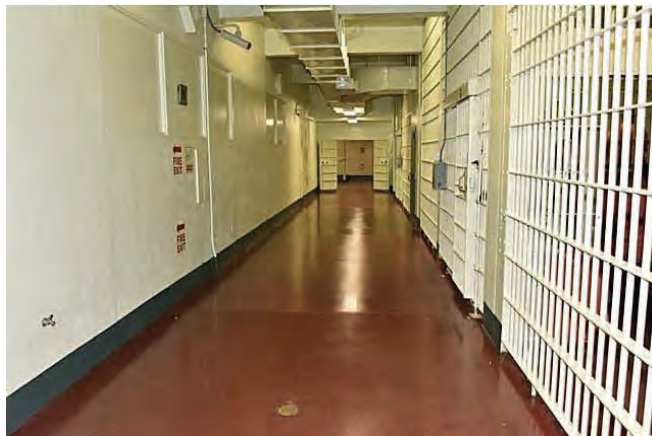
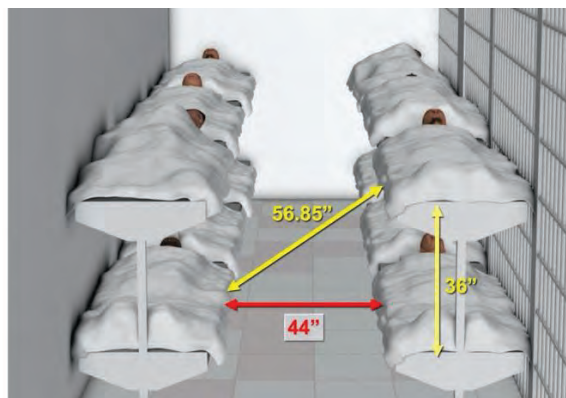


Photo: Corridor alongside the “tanks” in the “Old Jail”¹⁹

Each “tank” has space for between eight and twenty detainees who sleep in sets of bunk beds spaced only a few feet apart and around a common area reserved for eating and use of the lavatory.²⁰ The bunkbeds in G, H, K and L are only 3’8” apart horizontally, and apparently only inches apart vertically; and in J only 8’ apart horizontally and apparently inches apart vertically. (The exact distances in I-tank are unavailable.)



¹⁹ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Pablo Stewart MD in support of Plaintiffs’ Motion to Enforce Consent Decree and for Further Remedial Orders in *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (Dkt. 220 at 182, Sept. 1, 2017).

²⁰ *G-, H-, K- and L-tanks* each have capacity for 20 detainees in ten bunk beds in 580 square feet of space. In each of these tanks, there are 6 bunks on one side of a common area (divided into two rows of 3 bunks each) and four bunks on the other side of the common area. There is 3’8” between the bunks and each sleeping side measures 142 square feet. *I-tank* has capacity for 8 detainees in 4 bunks in 270 square feet. *J-tank* has capacity for 12 detainees in 6 bunks in 548 square feet (286 square feet for the common area and 262 square feet for the sleeping area). In *J-tank*, there are two bunks on one side of the sleeping area, three bunks on the other side and one bunk on the end. The rows of bunk beds are eight feet across from one another.

These “tanks” are currently, based on the numbers available, 45%-75% full. These housing units are particularly unsafe because of the significant number of people in close quarters, the inability to move the bunk beds, and the air flow between the neighboring tanks, making an even greater congregate living environment than the population level of each tank suggests.

G-tank is a single story housing unit, approximately 580 sq. feet and consisting of ten bunks.

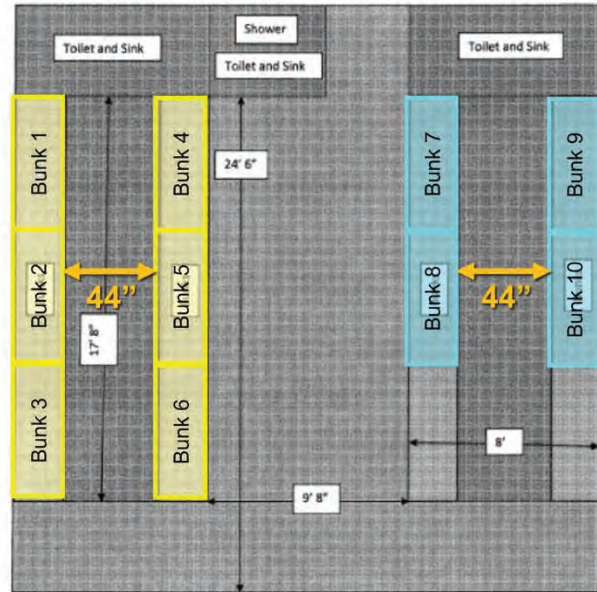
The sleeping areas are divided by a common area, which measures approximately 236 sq. feet and consists of a mounted table, a shower, a toilet, and a sink.

The shower is approximately 3'2" deep and 2'10" wide. The sink and toilet are spaced approximately 1'9" apart.

On one side of the common area, a sleeping area is approximately 142 sq. feet and consists of six bunks, one toilet, and one sink. The six bunks are separated by 3'8", with three on each side.

On the other side of the common area is another sleeping area, which is approximately 142 sq. feet and consists of four bunks, one toilet, and one sink. These bunks are also separated by 3'8". Each bunk is approximately 6'6" long, 2'6" wide, and separated by 36" vertically.

The vertical height of G-tank is approximately 12'5".



35. This is described vividly by declarants familiar with the facilities: One said, “the rows of beds are close together, and you can reach out and touch the one next to you.”²¹ Another described: “when one person is asleep and their feet are sticking out of the bed, their feet are about 6 inches from the next person’s head in front of them.”²² A third identified that detainees walk between the beds in a narrow hallway, further limiting the possibility of social distancing.²³ Even when the tanks were occupied at half-capacity, detainees express that social distancing is impossible.²⁴ This inability to practice social distancing at half-capacity is consistent with the measurements provided by Defendants and the photographs I have seen. One declarant in G-tank described, “we feel like rats in a cage.”²⁵

36. Single-, Double- and Quadruple-celled Units with Shared Common Area (D-, E- and F-pods, P-tank, A-pod, S-tank, Q cells, T-tank and N-tank): Yuba also has a limited

²¹ Marroquin Dec. ¶¶ 3, 5.

²² Mejia Rosas Dec. ¶¶ 4-5 (“If I look to my left, I can almost touch the person across from me with my hand. We are all approximately 2 feet or an arms length apart from each other when we are sleeping in our bunkbeds.”).

²³ Aguilar Dec. ¶ 7 (“when I’m lying in bed, if I stretch out my arm, I can touch the bed next to me. I can reach out and touch the other person. And if someone walks between the beds, it’s even closer.”).

²⁴ Erazo Dec. ¶¶ 4-5 (“H Tank was too small for us to engage in social distancing. There were 10 people crammed into the tank. It was impossible to be six feet away from other people... Two of the bunk beds had two people in them, the rest were singles. All the lower bunks were taken. While lying in bed, I could almost touch the person’s head in the bunk bed behind me with my toes. In my bed, I had a bunk bed on my left side, as well as at my feet.”).

²⁵ Aguilar Dec. ¶¶ 11-12.

number of four-person, two-person, and single cells.²⁶ In the quads, the bunkbeds are very close together—2’11” apart in P-tank and 5’ apart in Q-4 cell. In the double cells, there are fewer people in close quarters, but the upper and lower bunk remain very close, limiting the possibility of social distancing if both bunks are occupied.²⁷

B. Eating

1. Mesa Verde

37. There are two dining halls at Mesa Verde. Mesa Verde uses both dining halls and staggers mealtimes to limit the number of detainees in a dining hall to a maximum of 25 at any given time. The detention center authorities have recently modified meals at Mesa Verde so that individual detainees are eating one person at a table at a time.
38. Detainees still describe limitations in social distancing when they line up for meals, however. As one declarant provided: “When guards call “prep for chow,” we line up in a single file—like elementary school kids lined up for lunch or people lined up for an amusement park ride—inches apart from the person in front and behind us. We wait in line, shoulder to shoulder, for about 20 to 30 minutes to leave our dorm room to go to the dining hall... We have to line up again inches from each other once it’s

²⁶ *D, E and F pods* each include twenty-two-person cells where individuals sleep in bunk beds. The two-person cells measure 6’ x 11’7”. The detainees have a shared common area in each pod. In *P-tank*, there are three two-person cells and one four-person cell, as well as one bunk in a common area, making the total capacity of the tank 12 detainees. Each of the two-person cells have one bunk, one sink and one toilet and are between 52- and 62-square feet. The four-person cell has two bunks 2’11” apart, one sink and one toilet, and is 84 square feet. The common area (310 square feet) has one additional bunk as well as a sink, toilet and table. *A-pod* has 20 two-person cells measuring 6’x11’7” each and containing a toilet, sink and bunk beds. There is a shared common area used for eating and showering. This has separately been described as an administrative segregation unit for men, though that is not affirmed in Defendants’ responses to the interrogatories. *S-tank* has capacity for 12 detainees in six two-person cells of 56 square feet each. Each cell has a bunk bed, sink, and toilet. This has separately been described as an administrative segregation unit for women, though that is not affirmed in Defendants’ responses to the interrogatories. There are five “*Q cells*”—two two-person cells (Q1 and Q2, with one bunk bed, one toilet and one sink and measuring 120 and 93 square feet, respectively), one one-person cell (Q3, with one bed, one sink, and one toilet and measuring 67 square feet), and one four-person cell (Q4, consisting of two bunks, one toilet, and one sink and measuring 165 square feet). Detainees in Q cells use a common shower near the S cells or N-tank. *T-tank* is a single two-person unit of 300 square feet with one bunk bed, one toilet, one sink, one shower and one mounted table. (Relying on the Berg Report, in my original declaration, I described “T” as a room with multiple bunks. Defendants’ responses to the interrogatories provide that “T-tank” is now a “two-man unit.”) *N-tank* consists of 13 separate single cells of 52 square feet each, with one bed, one toilet and one sink in each cell, and a common area with a shared table.

²⁷ Singh Dec. ¶¶ 5, 7 (“I share a cell, and my bunkie and I are very close almost all the time. I sleep on the bottom bunk. When my roommate hangs his hand from the top bunk, it could touch my face. We can’t be more than 2 ½ feet apart. When you’re in the cell, if your roommate didn’t brush their teeth, you can smell their breath. I am locked in my cell with my bunkie for about 18 hours a day.”); Birru Dec. ¶ 5 (“We try to distance ourselves from one another by each staying on our own bunks most of the time, but it is still not six feet apart. We are in our cells for 21 hours every day. It’s really difficult.”).

time for us to go back to our dorm.”²⁸

2. Yuba County Jail

39. Detainees at Yuba County Jail take all meals in their respective housing units. All of the units have shared eating areas – either within the dormitory or in a shared common space – used by up to 20 or more people. In most cases, the dining areas are fixed tables in either a common space separate from the sleeping area or in the middle of the sleeping area or areas.²⁹
40. Defendants have not provided information about the number of seats at each table or how far apart they are from each other. However, photographs depict group tables where detainees would be sitting shoulder to shoulder if neighboring seats were occupied. (See below.)



Photo: “Day room” or common area in one of the tanks³⁰

41. The declarations of class members confirm this. One declarant in the B-pod dormitory described: “Sometimes, we sat right next to each other, and our elbows bumped as we

²⁸ Masoom Dec. ¶ 8. *See also* Garcia Montes at 9 (“even with staggered meals, we still have to wait in a tight line, inches from people, to leave the dorm and go to the dining hall. There’s no distancing at all. It doesn’t matter that we each sit at our own table to eat because we’re only in the dining hall for 10 minutes. It’s so rushed now, because they’re taking us in smaller groups.”); Trujillo Dec. ¶ 7 (“There are about 25 of us at a time waiting in line to walk to the cafeteria, and while we are in the line, we are very close to one another. It is totally ridiculous because once we get to the cafeteria we sit at separate tables, but to get there we are within arms-length of each other in line and in the dorm.”).

²⁹ There are shared fixed tables in B and C pods, R-dorm, G through L tanks, D-, E-, and F-pods, P-tank, A-pod, and N-tank. There is a mounted desk in each double cell in S-tank and some of the Q-cells, and Defendants have provided no information about any shared area or structures for eating in these housing units. There is a mounted table in the double cell in T-tank.

³⁰ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Pablo Stewart MD in support of Plaintiffs’ Motion to Enforce Consent Decree and for Further Remedial Orders in *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (Dkt. 220 at 186, Sept. 1, 2017).

ate.”³¹ In the tanks, detainees “line up next to [their] bunks to get [their] food” and sit “shoulder to shoulder” at a long table fixed to the floor.³²

42. The one-, two-, and four-person cells typically have a fixed desk that may be used for eating, but also may stand in line close together and eat at fixed tables in close proximity.³³ (See photo below.)

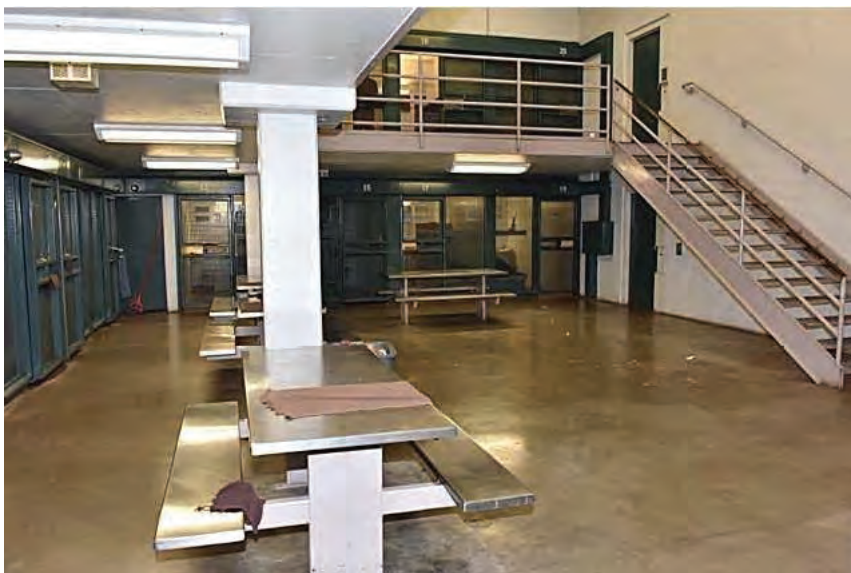


Photo: common area and shared tables for A-pod³⁴

C. Restrooms

1. Mesa Verde

43. The Mesa Verde dormitories have two shared bathrooms with seven sinks, five toilets and five showers each. There are side partitions between the toilets and the showers. The distance between sinks in each dorm is 24”. The distance between each toilet is 36” in A & B, and 29” in C & D. The distance between each shower is 36” in A & B and 31” in C & D. There are toilet and shower partitions but in all of the dorms, they start above the floor and do not go higher than 42”.

³¹ Pablo Dec. ¶¶ 6-7 (“[At meal time] we formed a single file line. The person serving stood about five or six feet away from us. I could easily touch the person in front of me in line if I wanted to, and the person behind me could touch me. The tables and benches on the second floor were welded to the ground, so we couldn’t move them ... we had to sit close together.”).

³² Marroquin Dec. ¶ 6. Mejia Rosas ¶ 8 (“the dining seats are approximately 7-8 inches apart and we are practically elbow-to-elbow during all three of our meals”); Aguilar Dec. ¶ 10.

³³ Singh Dec. ¶ 9 (“[In line,] the room is so small that we can only stand about one foot apart. You could breathe on the neck of the guy in front of you. After you are given your tray, you literally have to tell the last person in line excuse me so you could get by.”).

³⁴ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Pablo Stewart MD in support of Plaintiffs’ Motion to Enforce Consent Decree and for Further Remedial Orders in *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (Dkt. 220 at 169, Sept. 1, 2017).

44. Detainee declarants describe the lack of capacity for social distancing in the restrooms at Mesa Verde. They have described changes in response to COVID-19 including turning off selected sinks, toilets, showers and urinals to make them inoperable and increase the space between individuals in the bathrooms.³⁵ While this was partially effective in that respect, it led to increased proximity while waiting in line because of the limited number of sinks, toilets, showers and urinals.³⁶ Some detainees also report that this means that people are washing their hands less.³⁷

2. Yuba County Jail

45. In the Yuba dormitories, there are often shared toilets, sinks and showers close to one another—not permitting social distancing in the use of the lavatories.³⁸ This presents a high risk of infection. For instance, B and C pods, which currently have up to twenty people each, have restrooms in their two common areas—together six toilets, six sinks and three showers.³⁹ The toilets are 2’8” apart (and, in one case in each pod, 2’10” apart) and the sinks are 11” apart. This does not allow social distancing in the use of the lavatory. R-dorm has two toilets, two sinks, and two showers for up to 18 detainees, and a current population of seven. The showers are 2’10” apart and the sinks and toilets are each 6’2” apart. This does not allow for social distancing in the showers.⁴⁰

46. In tanks, people share the restrooms in each tank. Class members describe an inability to socially distance while using the lavatory and photographs depict the proximity of the toilet to others—and to the table where detainees eat. As one declarant described about the toilets in the tank, “Even the toilets are in an open aired space and do not afford any social distancing, let alone privacy.”⁴¹ (See photo below.) As another described, “There are three toilets, in a row, that are maybe three feet apart. There is a small separator between the toilets, but no door. So even while you go to the

³⁵ Massom Dec. ¶¶ 14-15; Garcia Montes Dec. ¶ 14; Trujillo Dec. ¶ 10.

³⁶ *Id.*

³⁷ Garcia Montes Dec. ¶ 14.

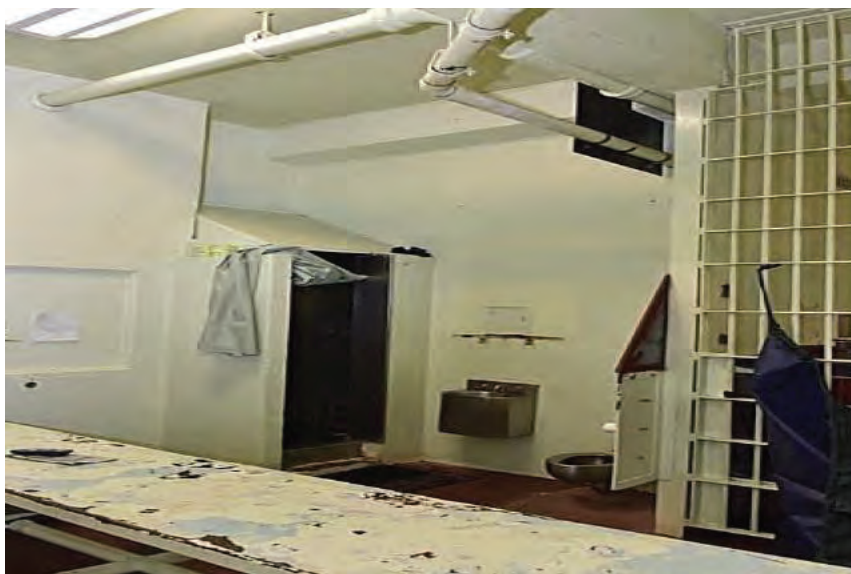
³⁸ Pinheiro Dec. ¶ 11 (“The stalls were very close together and when you showered you were only a few feet away from the person next to you, with the only thing separating you from the other person a moveable plastic divider that only covered up the area between your knees up to about your shoulders. There were two toilets in the bathroom, each with a sink. The toilets were only about two feet apart.”) (describing R-dorm); Pablo Dec. ¶ 9 (“The toilets are two or three feet away from each other. When sitting on the toilet, you could see the person next to you.”) (describing B-pod).

³⁹ In the lower common areas, there are two toilets, four sinks and one shower for each pod. In the upper common areas, there are four toilets, two sinks and two showers for each pod.

⁴⁰ In tanks, people share the restrooms in each tank. In the largest tanks – G-, H-, K-, and L-tanks, which have a capacity of up to 20 people and currently house up to 11 – there are 3 toilets, 3 sinks, and a shower. This includes one toilet, sink and shower in a central common area in the middle of the “tank” and a separate toilet and sink on each of two sleeping sides of the tank. The sinks are 1’9” from the toilets. Up to twelve detainees in J-tank share 2 toilets, 2 sinks and 1 shower. The common area includes a sink and toilet 1’1” apart, and a shower; and the sleeping area includes a separate toilet and sink. The smallest tank, I-tank (which houses up to 8 detainees) there is 1 toilet and 1 sink 1’4” apart and 1 shower.

⁴¹ Mejia Rosas Dec. ¶ 15.

bathroom, you can't get away from other people.”⁴²



Photos above: H-tank common area or “day room” including dining table and lavatory⁴³

47. In some of the single or double cells, there are toilets and sinks within the individual cells, in addition to shared toilets.⁴⁴ In these cases, the bigger issue concerns whether

⁴² Aguilar Dec. ¶ 13.

⁴³ Photo confirmed as presently accurate by Plaintiffs’ class member Aroldo Rodriguez Diaz. Photograph previously included as Exhibit to Declaration of Pablo Stewart MD in support of Plaintiffs’ Motion to Enforce Consent Decree and for Further Remedial Orders in *Hedrick v. Grant*, Case No. 2:76-cv-00162 (E.D. Cal.) (Dkt. 220 at 191-92, Sept. 1, 2017).

⁴⁴ Each one- two- or four-person cell in N-tank; A-, D-, E-, and F-pods; P- S- and T-tanks; and the Q cells has its own sink and toilet which may be shared by two or up to four detainees. (P-tank also has a separate sink

detainees are provided adequate resources for hygiene and sanitation to ensure that the toilets, sinks and showers are cleaned between each use. This is an even more significant issue in the lavatories that are shared by more individuals.

TRANSFERS

48. As the Centers for Disease Control has recommended, and I endorse, transfers between jails or detention centers in the middle of this pandemic are very ill-advised and should only happen in extraordinary circumstances. The CDC specifically recommends “suspend[ing] all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.”⁴⁵ The justification for this strong recommendation is the same justification that supports the recommendation of public health authorities to shelter in place and limit unnecessary movement: the virus spreads through the movement of infected individuals, with a particularly heightened risk of infectious spread where individuals are moving between congregate living environments.
49. In rare situations where a transfer is absolutely necessary, the CDC advises and I endorse screening and temperature checks, with testing where possible, and the use of personal protective equipment for the transfer, and appropriate isolation immediately subsequent to the transfer until an individual is confirmed to not be infected with COVID.

MEDICAL SEGREGATION

50. As I provided in a previous declaration (§ 56 of April 19 Declaration), isolation is not a proper solution for people without symptoms or confirmed COVID-19 disease. Being detained in a congregate environment during a pandemic, when congregate environments are known areas of heightened transmission, already has the potential to produce great anxiety and stress for those detained. Isolation may increase the anxiety and stress. Isolation also carries with it various additional risks and harms: less frequent monitoring, potentially delayed access to medical attention, greater risks of suicide or self-harm (with increased related physical and mental health risks for the individual and attendant mental health risks for the population), increased psychological stresses, and increased physical contact from handcuffing in transport and escorting to showers.
51. Isolation resembles solitary confinement (even more so if done in a segregation unit typically used for disciplinary violations and not a medical unit). People *without* pre-existing mental illness can suffer severe mental deterioration in solitary confinement, including depression,

and toilet 2’8” from each other in a common space.) The housing units then have shared showers elsewhere in the housing unit. For instance, in A-, D- and E-pods there are two showers each for up to 40 detainees. There is a common shower in S-tank in addition to the sinks and toilets found in each two-person cell. N-tank has two shared showers 6’6” apart for use by up to 13 individuals.

⁴⁵ CDC, “Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities,” May 7, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

self-mutilation and hallucination. These risks and harms of isolation outlined above are exacerbated for people who have pre-existing mental illness. Isolation in these cases can contribute to worsening mental illness.

52. As provided previously (§ 54 of April 19 Declaration) for people who *have* confirmed cases or are *suspected* to have confirmed cases, isolation may be appropriate for public health reasons. The risks and harms from isolation, listed above, remain and are serious. But where there are confirmed or suspected cases in a congregate environment, protection of the public health mandates short-term medical isolation. All efforts should be made to ensure that isolation is identified as medical isolation, not equated with segregation for disciplinary infractions and not in a segregation unit used for disciplinary purposes. If the purpose and time-limited nature of medical isolation is not clearly communicated, and distinguished from disciplinary segregation, the fear of being placed in isolation may deter individuals from coming forward to report symptoms, thus accelerating disease transmission.
53. There are effectively four types of quarantine. *First*, sequestering, or intake quarantine, is appropriate for fourteen days for a new arrival at a facility with surveillance and prompt isolation of entrants who develop symptoms.
54. *Second*, anyone who is symptomatic but not yet confirmed positive (i.e., because s/he has not yet been tested or pending test results) should be cohorted in a separate housing unit from others who do not have symptoms.
55. *Third*, all close contacts of infected individuals should be housed separately and monitored for fourteen days. This requires tracing the intramural contacts of someone who is confirmed infected. For instance, if someone is confirmed infected, those in the individual's housing unit and those who the individual otherwise came into contact with should be quarantined. In this case it may be appropriate to quarantine as a group though care must be taken to avoid anyone new being added to the group as any new additions must restart the clock for another fourteen days. Members of the group should be monitored at least twice a day for symptoms. If anyone in this cohort develops symptoms or is confirmed positive, they must be removed from the group, tested and housed with suspect cases. If the person tests positive, the clock must be reset and the group must remain in quarantine for fourteen days starting from that time.
56. *Fourth*, confirmed COVID-19 patients should be placed in medical isolation. Medical isolation for suspected or confirmed cases should continue until the person satisfies the following CDC criteria: (1) the person has been fever-free for 72 hours without fever-reducing medications; (2) any other COVID-19 symptoms have improved; and (3) either the individual has tested negative twice at an interval of at least 24 hours between testing; *or* if testing is unavailable, it has been at least 10 days since symptoms appeared (or if the person did not have symptoms, at least ten days since the first positive COVID-19 test).
57. Segregation or lockdown is not a medically appropriate method for abating the substantial risks of COVID-19. While medical isolation may be necessary to avoid transmission by

separating out confirmed or suspected cases, isolation of non-confirmed or non-suspected cases is never appropriate and has serious detrimental effects.

58. There are already concerning reports about the improper and detrimental use of isolation for non-confirmed or non-suspected COVID-19 cases at both Mesa Verde and Yuba. Specifically, I understand that an elderly man recently died by apparent suicide at Mesa Verde and his family and lawyer report that he was isolated at the time of his suicide. This is despite his having tested negative for COVID-19 at a hospital prior to his death.⁴⁶ Declarant Livia Pinheiro also provides in a declaration that she was told that she would be put in a “segregated housing unit” if she identified medical vulnerabilities, and that she was then moved into a segregated housing unit despite having serious mental health issues and no suspected or confirmed COVID-19.⁴⁷ As outlined above and in my prior declaration, isolation where individuals do not have confirmed or suspected COVID-19 is improper, and such a response to the risk of COVID-19 is inconsistent with medical and public health guidance.⁴⁸

CONCLUSIONS

59. Despite some population reductions and limited reforms that have been made to the layout and use of the facilities since I provided my initial and first supplemental declarations in this case, I remain very concerned that the conditions at Mesa Verde and Yuba place detainees in particular, but also staff and the surrounding community, at great risk given the COVID-19 pandemic.
60. Certain practices, such as limiting access to toilets and sinks in Mesa Verde, have had unintended adverse consequences of more people waiting in line in close proximity to others and barriers to more regular handwashing. Overall the response by detention center authorities to COVID-19 at these two facilities has not met the challenge of this grave public health threat head-on.
61. It is my opinion that ICE’s response to the threat of COVID-19 in Mesa Verde and Yuba has been woefully inadequate. It remains my professional opinion that the only way to achieve meaningful social distancing in these facilities is to significantly decrease their population levels. Detainees who have provided declarations in this case have described the absolute inability to practice social distancing in sleeping, eating, recreating and using the restroom and this is confirmed by the information provided by Defendants about the layout and population levels at the two facilities.

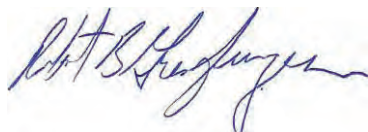
⁴⁶ Andrea Castillo, “ICE Said a 74-Year-Old Was Too Dangerous to Release. He Died of Apparent Suicide,” May 20, 2020, at <https://www.latimes.com/california/story/2020-05-20/immigrant-ice-detention-suicide-coronavirus>.

⁴⁷ Pinheiro Dec. ¶¶ 17-20.

⁴⁸ CDC, “COVID-19 Guidance for Correctional and Detention Facilities,” rev. May 7, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

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

Executed this 21st day of May, 2020 in Eastham, Massachusetts.

A handwritten signature in blue ink, appearing to read "Robert B. Greifinger", written over a light blue rectangular background.

Robert B. Greifinger, M.D.

ROBERT B. GREIFINGER, M.D.

380 Riverside Drive, Apt 4F
New York, New York 10025

(646) 559-5279
bob@rgreifinger.com

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

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

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

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

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

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

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

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

ROBERT B. GREIFINGER, M.D.

MONTEFIORE MEDICAL CENTER, Bronx, NY

1985 - 1989

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

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

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

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

WESTCHESTER COMMUNITY HEALTH PLAN, White Plains, NY

1980 - 1985

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

Vice President and Medical Director

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

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

COMMUNITY HEALTH PLAN OF SUFFOLK, INC.

1977 - 1980

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

Medical Director

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

MONTEFIORE MEDICAL CENTER, Bronx, NY

1976 - 1977

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

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

UNITED STATES PUBLIC HEALTH SERVICE

1972 - 1974

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

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

1976 - 2002

Assistant Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine

2005 - 2016

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

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

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

OTHER PROFESSIONAL ACTIVITIES

2012 – present Member, Board of Directors, Prison Legal Services, New York

2012 – present Member, Board of Directors, National Health Law Program

2011 – 2015 Member, Board of Directors, Academic Consortium of Criminal Justice Health

2010 - 2016 Co-editor, International Journal of Prisoner Health

2009 Recipient, B. Jaye Anno Award for Lifetime Achievement in Communication

2007-2015 Member, National Advisory Group on Academic Correctional Health Care

2007 Recipient, Armond Start Award, Society of Correctional Physicians

2005 - 2011 Member, Advisory Board to the Prisoner Reentry Institute, John Jay College

2002 - present Member, Editorial Board, Journal of Correctional Health Care

2002 - present Peer reviewer for multiple journals, including Journal of Correctional Health Care, International Journal of Prison Health, Journal of Urban Health, Journal of Public Health Policy, Annals of Internal Medicine, American Journal of Public Health, Health Affairs, and American Journal of Drug and Alcohol Abuse.

2001 - 2003 Member, Advisory Board to CDC on Prevention of Viral Hepatitis in Correctional Facilities

1999 - 2003 Member, Advisory Board to CDC on Prevention and Control of Tuberculosis in Jails

1997 - 2003 Member, Reconsideration Committee, NCQA

1997 - 2001 Moderator, Optimal Management of HIV in Correctional Systems, World Health Communications

1997 - 2000 Member, Reproductive Health Guidelines Task Force, CDC

1993 - 1995 Co-chair, AIDS Clinical Trial Community Advisory Board, Albany Medical Center

1992 - Present Society of Correctional Physicians

1991 - 1997 Member, Review Oversight (accreditation) Committee, NCQA

ROBERT B. GREIFINGER, M.D.

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

EDUCATION

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

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

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

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

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

License: New York, Pennsylvania (inactive)

ROBERT B. GREIFINGER, M.D.

Updated February 2018

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