UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

J.H., by and through his mother and next friend, N.H.; I.B., by and through his parents and next friends, A.B. and I.B., on behalf of themselves and all others similarly situated,

Plaintiffs-Petitioners,

-against-

JOHN BEL EDWARDS, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF LOUISIANA; THE LOUISIANA OFFICE OF JUVENILE JUSTICE; EDWARD DUSTIN BICKHAM, IN HIS OFFICIAL CAPACITY AS INTERIM DEPUTY SECRETARY OF THE LOUISIANA OFFICE OF JUVENILE JUSTICE; JAMES WOODS, IN HIS OFFICIAL CAPACITY AS THE DIRECTOR OF THE ACADIANA CENTER FOR YOUTH; SHANNON MATTHEWS, IN HER OFFICIAL CAPACITY AS THE DIRECTOR OF THE BRIDGE CITY CENTER FOR YOUTH; SHAWN HERBERT, IN HER OFFICIAL CAPACITY AS THE DIRECTOR OF THE SWANSON CENTER FOR YOUTH AT MONROE; and RODNEY WARD, IN HIS OFFICIAL CAPACITY AS THE DEPUTY DIRECTOR OF THE SWANSON CENTER FOR YOUTH AT COLUMBIA,

Defendants-Respondents.

CIVIL ACTION NO. 3:20-cv-00293-JWD-EWD

CLASS ACTION

REPLY MEMORANDUM IN SUPPORT OF PLAINTIFFS-PETITIONERS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER[1]

[1] This Court granted Plaintiffs-Petitioners leave to file a reply memorandum in support of their Motion for TRO during the Telephone Status Conference held on May 20, 2020. *See* Dkt. 21 at 2.

I. Introduction

The evidence provided by Defendants confirms, rather than rebuts, the disturbing facts in Plaintiffs' Motion for TRO, and the pressing need to protect Louisiana's detained children through emergency injunctive relief. Specifically, Defendants' Opposition admits the following facts:

- OJJ has not administered any initial COVID-19 tests to children in its secure care facilities since April 12;[2]
- OJJ has tested only 30 children total;[3]
- Of the 30 children OJJ has tested for COVID-19, 28 tested positive initially—93%;[4]
- OJJ does not administer COVID-19 tests to any children who do not outwardly display specific symptoms;[5] and
- All furloughs have been postponed since March 16.[6]

Additionally:

- As of May 26, 48 OJJ staff members have tested positive—at least eight more than when Plaintiffs filed their Motion for TRO on May 15;[7]
- Seventeen children currently in OJJ's secure care facilities have been identified as 'Chronic Care' as of May 22;[8]
- The facilities are still not providing adequate educational and rehabilitative programming;[9]
- The children are still confined indoors for excessively long periods of time;[10]
- Parents are still unable to speak to their children regularly, and OJJ is still refusing to share information with them regarding the facilities' COVID-19 policies;[11] and
- Louisiana now has at least 17 confirmed cases of the serious pediatric condition, now called multisystem inflammatory syndrome in children ('MIS-C') or pediatric inflammatory multi-system syndrome ('PIMS'), that is linked to COVID-19.[12]

---

[2] List of Youth Tested for COVID-19, Dkt. 25-3 at 34-35.
[3] *Id.*
[4] *Id.*
[5] *See* Defs.' Opp'n to TRO at 5 ('Youth who are not exhibiting symptoms of COVID-19 are not tested for the disease.').
[6] *See* Defs.' Opp'n to TRO at 5 ('Beginning March 16, 2020, all off-site programming was suspended, and furloughs were postponed.').
[7] OJJ COVID-19 Information, La. Office of Juvenile Justice, https://ojj.la.gov/ojj-covid-19-information/ (last visited May 26, 2020); Pls.' Memo. in Support of TRO, Dkt. 7-1 at 10.
[8] Ex. 1, OJJ Chronic Care List.
[9] Ex. 2, J.P. Decl. at ¶ 8.
[10] *Id.*
[11] *Id.* at ¶¶ 7, 9.
[12] Ex. 3, Maraynes Decl. at ¶ 8; *see also* Emily Woodruff, *There are 11 Louisiana cases of the pediatric inflammatory condition that's linked to coronavirus*, NOLA.COM (May 22, 2020 at 12:57 PM), https://www.nola.com/news/coronavirus/article_cc495d86-9c55-11ea-bf78-87380aa2aa98.html.

Defendants continue to ignore the dire threat that COVID-19 poses to the children in their care, and they continue to maintain increasingly unsafe and non-rehabilitative conditions of confinement that violate Plaintiffs' constitutional rights. As this untenable situation worsens each day, Plaintiffs respectfully request that this Court grant their Motion for Temporary Restraining Order.[13]

II. Plaintiffs Have Satisfied the Exhaustion Requirement of the Prison Litigation Reform Act (PLRA)

Defendants claim (1) that Plaintiff must file Administrative Remedy Procedure ('ARP') grievances themselves, rather than have them filed by a parent or an attorney; and (2) that Plaintiffs must use the non-emergency grievance procedure if their emergency grievance is not responded to within the 48-hour or 5-day timeline.[14] Neither of these arguments has merit. To comply with the PLRA, the grievance must 'reasonably indicate a problem' and give officials 'fair notice' of the problem at issue.[15] Defendants' reliance on *Gates v. Cook* is misplaced. In that case, the Court concluded that the prisoner was *not* required to use the regular grievance process after completing an emergency request.[16] Moreover, in cases involving juveniles confined to secure care facilities, courts have interpreted grievance procedures generously to avoid findings of non-exhaustion.[17]

---

[13] Plaintiffs' Motion for TRO seeks an order immediately enjoining Defendants from (1) continuing to confine all children who are currently within 180 days of their release dates; (2) continuing to confine children who are presumptively eligible for release, including all children who are eligible for furlough under OJJ's criteria as well as those who have contracted the disease and those who are medically vulnerable; (3) failing to test children for COVID-19; (4) using Behavioral Intervention Rooms for any child who tests positive for COVID-19 or displays symptoms of the disease; (5) confining children to their dormitories for lengthy periods of time; (6) using pepper spray on children; and (7) continuing the suspension of structured educational and rehabilitative programming in OJJ facilities. Plaintiffs also ask that this Court order Defendants to develop, within 48 hours, an effective COVID-19 response plan governing the state's four children's detention centers that fully conforms to CDC guidelines. *See* Pls.' Mot. for TRO, Dkt. 7.

[14] A legislative audit from 2018 found that OJJ did not address 19% of youth grievances within the appropriate timelines. Performance Audit Services, Oversight of Safety in Secure Care Facilities, (June 6, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/$FILE/000194C2.pdf.

[15] *Johnson v. Johnson*, 385 F.3d 503, 518–19 (5th Cir. 2004).

[16] *Gates v. Cook*, 376 F.3d 323, 331–32 (5th Cir. 2004).

[17] *See Lewis v.* Gagne*, 281 F.Supp.2d 429, 433-35 (N.D.N.Y. 2003) (holding that a mother had made sufficient 'reasonable efforts' to exhaust, without explicitly commenting on the juvenile's own status); *see also Troy D. v. Mickens*, 806 F.Supp.2d 758, 768-69 (D.N.J. 2011) (holding ombudsman procedure was exhausted by an attorney's letter to juvenile institution superintendent); *Moore v. Louisiana Dept. of Public Safety and Corrections*, 2002 WL

Counsel for Plaintiffs filed Third-Party emergency grievances on behalf of I.B. and J.H. on May 8 and 9, respectively, via email to the relevant facility directors.[18] State law and the OJJ Administrative Remedy Procedure expressly encompass Third-Party ARPs, and Third-Party ARPs by attorneys in particular.[19] Counsel sent the emergency grievances according to instructions she received over the phone from the facilities.[20] Counsel did not receive a response to either grievance within 48 hours or 5 business days,[21] as laid out in the ARP policies and procedures, thereby exhausting the emergency grievance process or, alternatively, establishing that it is unavailable.

The only deficiency Defendants allege as to these otherwise legally and factually sufficient emergency grievances is that OJJ staff incorrectly instructed Counsel on whom to direct the grievances. The facility directors could have simply sent the grievances to the unnamed ARP coordinators,[22] but doing so would have been pointless per internal policy, because in the case of a grievance 'which alleges substantial risk of imminent personal injury or cause serious or irreparable harm,' the ARP Coordinator 'shall immediately forward' the grievance or the relevant portion of the grievance to upper management, including *the facility directors* themselves.[23] Defendants' Opposition indicates that the emergency grievances should have been rejected—though, of note, no notice of rejection has been sent to Counsel for Plaintiffs. Under state law and

---

1791996, *4 (E.D.La., Aug. 5, 2002) (declining to enforce 30-day time limit; declaring 30-day delay in filing complaint 'not unreasonable' given that the plaintiff was a juvenile in state custody).

[18] Ex. 4, Kumar Decl. at ¶¶ 3, 6; Ex. 5, J.H. Emergency Grievance.

[19] La. Admin. Code tit. 22 § 713; Office of Juvenile Justice, Administrative Remedy Procedure B.5.3 at VII.F.4, VII.I (July 31, 2018), *available at* https://ojj.la.gov/wp-content/uploads/2019/08/B.5.3.pdf. That Counsel represented J.H.'s mother and I.B.'s parents, and had not entered into a client retainer agreement with minor children, which is an unenforceable contract under state law, is of no issue here. A completed Third-Party Acknowledgment/Approval Form that was included is what is required for a non-parent or guardian to file an ARP on a child's behalf.

[20] Ex. 4, Kumar Decl. at ¶¶ 2-3, 5-6.

[21] *Id.* at ¶ 7.

[22] Furthermore, an official giving wrong information on the ARP procedure can make that process 'unavailable.' *See Dillon v. Rogers*, 596 F.3d 260, 268 (5th Cir. 2010).

[23] Office of Juvenile Justice, Administrative Remedy Procedure B.5.3 at VII.I (July 31, 2018), *available at* https://ojj.la.gov/wp-content/uploads/2019/08/B.5.3.pdf

OJJ policy, rejection of an ARP is sufficient for exhaustion.[24] In any event, given that Defendants assert failure to exhaust based upon misinformation *they themselves* supplied, and upon which Plaintiffs *reasonably relied*, that defense should be equitably estopped.[25]

Relevant though not necessary to establish compliance under the PLRA, I.B. also attempted to file an emergency grievance through the procedures outlined in OJJ policy, though it was construed by OJJ staff as five separate, non-emergent ARPs.[26] Furthermore, N.H. filed an emergency grievance on J.H.'s behalf using the procedures outlined in OJJ policy.[27] OJJ failed to respond to these grievances as well, as required, within 48 hours or 5 calendar days, indicating administrative remedies are not currently 'available.'[28] Moreover, they failed to communicate whether these grievances had been considered and been rejected as emergent and were instead being treated as non-emergent, and would be replied to within 30 days of filing per OJJ policy.

---

[24] *Id.* at VII.H ('If a youth's ARP is rejected…he may seek judicial review of the decision within 30 calendar days following receipt of the decision.').

[25] *See Ziemba v. Wezner,* 366 F.3d 161, 163 (2d Cir. 2004) (holding that PLRA's exhaustion requirement is subject to equitable estoppel); *Wright v. Hollingsworth,* 260 F.3d 357, 358 n.2 (5th Cir. 2001); *Wendell v. Asher,* 162 F.3d 887, 890 (5th Cir. 1998) (stating that the amended PLRA statute imposes an exhaustion 'requirement, rather like a statute of limitations, that may be subject to certain defenses such as waiver, estoppel, or equitable tolling'); *Lewis v. Washington,* 300 F.3d 829, 834 (7th Cir. 2002) (noting that the Fifth Circuit's application of estoppel to PLRA exhaustion was 'persuasive.'). The applicable elements of equitable estoppel are set forth in *Carson v. Dynegy, Inc.*, 344 F.3d 446, 453 (5th Cir. 2003) ('(1) the plaintiff must know the facts of the defendant's [] conduct; (2) the plaintiff must intend that its conduct shall be acted on or must so act that the defendant has a right to believe that it is so intended; (3) the defendant must be ignorant of the true facts; and (4) the defendant must rely on the plaintiff's conduct to its injury.').

[26] Dkt. 25 at Exhibit E-3 at 1-5.

[27] Office of Juvenile Justice, Administrative Remedy Procedure B.5.3 at VII.I (July 31, 2018), *available at* https://ojj.la.gov/wp-content/uploads/2019/08/B.5.3.pdf.

[28] *See Valentine v. Collier*, -- U.S. --, 2020 WL 2497541, *1 (May 14, 2020) ('I caution in these unprecedented circumstances, where an inmate faces an imminent risk of harm that the grievance process cannot or does not answer, the PLRA's textual exception could open the courthouse doors where they would otherwise stay closed.'). A legislative audit from 2018 found that OJJ did not address 19% of youth grievances within the appropriate timelines. Oversight of Safety in Secure Care Facilities, Office of Juvenile Justice (June 6, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/$FILE/000194C2.pdf.

The risk of COVID-19 is indeed an emergency situation, and the normal 51-day window for exhaustion is untenable. OJJ has not responded to a single emergency grievance request, which could be rejected and put through the non-emergent grievance request process if necessary.

III. Defendants Are Violating Plaintiffs' Constitutional Rights

A. Plaintiffs' Conditions of Confinement Are Subject to the Liability Standards of the Due Process Clause of the Fourteenth Amendment

Unlike adults who are in prison, Plaintiffs' claims regarding the conditions of their confinement are subject to the liability standards of the Due Process Clause of the Fourteenth Amendment, not the Eighth.[29] While the Supreme Court has never explicitly stated which standard applies in juvenile justice facilities, the Court has made clear that the Eighth Amendment 'was designed to protect those convicted of crimes'[30] and is therefore not the appropriate standard for reviewing the disciplining of students in schools[31] or the conditions of confinement for other categories of individuals involuntarily committed for non-punitive reasons, such as mental health treatment.[32] Various federal appellate and district courts have concluded that when '[t]he chief objects of [a juvenile justice system] are educational and reformatory,' the 'system is noncriminal and nonpenal,' and 'the fourteenth amendment applies to conditions of confinement.'[33]

---

[29] Defendants concede this. *See* Defs.' Opp'n to TRO at 22 n.19 ('To the extent Plaintiffs are attempting to make a 'conditions of confinement' allegations, the liability test for such claims is whether 'a particular condition or restriction of pretrial detention is reasonably related to a legitimate governmental objective.'').

[30] *Ingraham v. Wright*, 430 U.S. 651, 664 (1977).

[31] *Id.*

[32] *Youngberg v. Romeo*, 457 U.S. 307, 325 (1982).

[33] *Gary H. v. Hegstrom*, 831 F.2d 1430, 1432 (9th Cir. 1987); *see also H.C. v. Jarrard*, 786 F.2d 1080, 1085 (11th Cir. 1986); *Santana v. Collazo*, 714 F.2d 1172, 1180 (1st Cir. 1983) ('[B]ecause the state has no legitimate interest to punishment, the conditions of juvenile confinement, like those of confinement of the mentally ill, are subject to more exacting scrutiny than conditions imposed on convicted criminals.'); *Milonas v. Williams*, 691 F.2d 931, 942 n.10 (10th Cir. 1982) ('Any institutional rules that amount to punishment of those involuntarily confined prior to an adjudication of guilt of criminal wrongdoing are violative of the due process clause per se.'); *A.J. ex rel. L.B. v. Kierst*, 56 F.3d 849, 854 (8th Cir. 1995) ('[W]e conclude that, as a general matter, the due process standard applied to juvenile pretrial detainees should be more liberally construed than that applied to adult detainees.'); *R.G. v. Koller*, 415 F. Supp. 2d 1129, 1152 (D. Haw. 2006) (holding that the Fourteenth Amendment governs the constitutionality of conditions for youths 'are adjudicated delinquent and have not been convicted of a crime.').

Under the Louisiana Constitution, the sole purpose of OJJ custody is to provide 'rehabilitation and individual treatment,' not to punish.[34] Thus, 'there is no need here, as there might be in an Eighth Amendment case, to determine when punishment is unconstitutional.'[35] Although the Fifth Circuit has not yet decided whether the Fourteenth Amendment standard applies to conditions of confinement cases involving the rights of youth in OJJ custody, courts around the country have acknowledged that 'when a state incarcerates juveniles for the purpose of treatment or rehabilitation,' as Louisiana does, 'due process requires that the conditions of confinement be reasonably related to that purpose.'[36] Indeed, some courts have found that youth in the juvenile justice system have a 'right under the [Fourteenth] Amendment due process clause to rehabilitative treatment' even in the absence of a statutory basis.[37] Thus, in light of Louisiana's express requirement that Plaintiffs be held in OJJ custody solely for rehabilitation and individual

[34] Pursuant to Louisiana Constitution Article V, § 19, the nature of the juvenile justice system is a non-criminal 'focus on rehabilitation and individual treatment rather than retribution, and the state's role as *parens patriae* in managing the welfare of the juvenile in state custody.' *In re C.B.*, 708 So. 2d 391, 397 (La. 1998). Defendants' argument that Plaintiffs' references to the Louisiana Constitution are irrelevant because there are no state law claims in this case misunderstands federal constitutional law; rights created by state law trigger protections under the U.S. Constitution. *See, e.g.*, *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972) (holding that where state law creates a 'legitimate claim of entitlement,' that entitlement is protected by procedural due process rights under the U.S. Constitution).

[35] *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2475 (2015).

[36] *Alexander S. v. Boyd*, 876 F. Supp. 773, 796 n.43 (D.S.C. 1995) ('[This theory] finds support in the Supreme Court's pronouncement in *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), that 'due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.''); *see also Morgan v. Sproat*, 432 F. Supp. 1130, 1135 (S.D. Miss. 1977) ('First, where, as in Mississippi, the purpose of incarcerating juveniles in a state training school is treatment and rehabilitation, due process requires that the conditions and programs at the school must be reasonably related to that purpose.'); *State ex rel. S.D.*, 832 So. 2d 415, 433 ((La. App. 4 Cir. 2002) (same).

[37] *Nelson v. Heyne*, 491 F.2d 352, 360, 360 n.12 (7th Cir. 1974) ('Since we have today determined that the federal Constitution affords juveniles a right to treatment, any interpretation of [state law] which would find no such right to exist would itself be unconstitutional.'); *see also Pena v. N.Y. State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976) ('[T]his court finds that the detention of a youth under a juvenile justice system *absent provision for the rehabilitative treatment of such youth* is a violation of due process rights guaranteed under the Fourteenth Amendment.') (emphasis in original); *Inmates of Boys' Training Sch. v. Affleck*, 346 F. Supp. 1354, 1364 (D.R.I. 1972) ('[D]ue process in the juvenile justice system requires that the post-adjudicative stage of institutionalization further this goal of rehabilitation.').

treatment services, Plaintiffs' claims are subject to the liability standards of the Fourteenth Amendment.

Under this standard, the subjective deliberate indifference test advanced by Defendants is not the proper inquiry. In its applications of the Fourteenth Amendment to other nonpunitive custodial settings, the U.S. Supreme Court has declined to adopt the subjective deliberate indifference test, instead modifying the standard based upon the purpose of the confinement and the corresponding duties owed to individuals in custody.[38] Further, the Supreme Court has made clear that constitutional standards must take into account the heightened protection owed to adolescents.[39] Thus, conditions of confinement that conflict with OJJ's duty to provide Plaintiffs with rehabilitation and individual treatment services—as required under the Louisiana Constitution[40]—violate Plaintiffs' Fourteenth Amendment rights even if they do not rise to the level of cruel and unusual punishment under the Eighth Amendment.[41]

Defendants' reliance on the Fifth Circuit's holdings in *Hare* and *Alderson* to argue that the appropriate standard is deliberate indifference is misplaced. First, those cases involved 'episodic

---

[38] *See Youngberg*, 457 U.S. at 323 (concluding that involuntarily committed mental health patients are entitled to greater protections than convicted prisoners and imposing liability under the Fourteenth Amendment when conditions amount to a 'substantial departure from accepted professional judgment, practice, or standards'); *see also Kingsley*, 135 S. Ct. at 2473 (rejecting application of the subjective deliberate indifference standard to a pretrial detainee in the excessive force context).

[39] *See Roper v. Simmons,* 543 U.S. 551 (2005) (holding the death penalty unconstitutional as applied to adolescents because, as a class, youth are less culpable, more impulsive, and more susceptible to change); *see also Graham v. Florida,* 560 U.S. 48 (2010) (holding certain life without parole sentences unconstitutional as applied to youth because of these same characteristic and noting that the distinctions are based not only in developmental research, but also in recent studies of the adolescent brain); *JDB v. North Carolina,* 564 U.S. 261 (2011) (requiring a more protective standard in the context of juvenile interrogations).

[40] *See supra*, note 34. Additionally, because Louisiana law grants Plaintiffs a right to rehabilitative services, procedural due process guarantees that Plaintiffs cannot be deprived of such services absent notice and a hearing. *Bd. of Regents*, 408 U.S. at 577 (holding that where state law creates a 'legitimate claim of entitlement,' that entitlement is protected by procedural due process rights).

[41] While some courts have held that children confined in juvenile justice facilities are protected by the Eighth Amendment in addition to the Fourteenth, the Fourteenth Amendment standard is 'more protective,' and its Due Process Clause 'implicitly incorporates the cruel and unusual punishments clause standards as a constitutional minimum.' *Gary H.*, 831 F.2d at 1432.

acts or omissions,'[42] while this is a case about conditions of confinement.[43] Second, this case is about children in the juvenile justice system, not adults in jail, which, as described above, necessitates a more protective standard.

Defendants' reliance on *Morales v. Turman* in their attempt to reject a juvenile-specific standard is similarly inapt. *Morales* concluded that the unconstitutional conditions in question could be remedied under the Eighth Amendment and that there was therefore no need for the Court to decide whether the Fourteenth Amendment standard also applied.[44] Also, the decision predated the Supreme Court's holding in *Youngberg* that the Fourteenth Amendment standard applies to questions regarding the conditions of confinement for people who are involuntarily committed for non-punitive reasons,[45] and the case arose out of Texas, where—unlike in Louisiana[46]—there was no clear state law right to rehabilitation.[47] Post-*Youngberg*, and given the non-punitive purpose of the Louisiana juvenile justice system, one would expect the Fifth Circuit to join the majority of Circuits Courts and protect Louisiana's detained children under the Fourteenth Amendment.[48]

---

[42] *Hare v. City of Corinth*, 74 F.3d 633, 643 (5th Cir. 1996) (en banc); *Alderson v. Concordia Par. Corr. Facility*, 848 F.3d 415, 419 (5th Cir. 2017).
[43] *Hare*, 74 F.3d at 644 ('Constitutional attacks on general conditions, practices, rules, or restrictions of pretrial confinement are referred to as jail condition cases.').
[44] *Morales v. Turman*, 562 F.2d 993, 998-99 (5th Cir. 1977).
[45] *Youngberg*, 457 U.S. at 325.
[46] *See supra*, note 34.
[47] *Morales*, 562 F.2d at 999.
[48] The Fifth Circuit cases interpreting the Supreme Court's holding in *DeShaney v. Winnebago C'nty Dept. Soc. Servs.*, 489 U.S. 189 (1989) also indicate that the Fourteenth Amendment is the proper standard. In *DeShaney*, the Supreme Court declined to recognize a constitutional duty to protect against harm caused by a private actor to a child who was not in state custody. *Id.* at 195-97. Nonetheless, the Court acknowledged that certain 'special relationships' created or assumed by the State with respect to particular individuals could give rise to an affirmative duty to provide adequate protection under the Fourteenth Amendment. *Id.* at 197-98. The Supreme Court identified incarceration and involuntary institutionalization as two circumstances when such a relationship—and corresponding duty to protect—exists, and the Fifth Circuit has explicitly 'extended the special relationship exception to the placement of children in foster care.' *Doe v. Covington C'nty Sch. Dist.*, 675 F.3d 849, 856 (5th Cir. 2012) (en banc). Children in OJJ custody have been confined against their will and are wholly dependent upon the state for their basic needs, and thus are similarly entitled to care and protection under the substantive due process protections of the Fourteenth Amendment. *See id.* ('[T]he state assumes a constitutional duty to care for children under state supervision because 'the state's duty to provide services stems from the limitation which the state has placed on the individual's ability to act on his own behalf.'' (quoting *Griffith v. Johnston,* 899 F.2d 1427, 1439 (5th Cir.1990)).

B. OJJ's COVID-19 Response Is Objectively Unreasonable and Has Rendered the Conditions of Confinement Unsafe and Punitive, Rather than Rehabilitative

Defendants concede that, at most, Plaintiffs' claims regarding the conditions of their confinement are subject to a standard that asks whether OJJ's COVID-19 policies are rationally related to legitimate governmental objectives.[49] As described above, in cases about a state's rehabilitative juvenile justice system, this means that policies must be rationally related to the rehabilitative goals of the system. Plaintiffs are entitled to relief because OJJ's actions in response to the COVID-19 pandemic are objectively unreasonable under any standard—making children significantly *less* safe, and the conditions of their confinement more dangerous, by directly contradicting CDC and other professional guidance. OJJ's restrictive and dangerous actions therefore serve no legitimate purpose and constitute punishment rather than rehabilitation.[50]

Refusing to release or furlough children serves no legitimate purpose and exposes children to an increased risk of infection and transmission.[51] Defendants' argument that they cannot use furlough because they cannot conduct home inspections is unconvincing. It does not account for the youth who have already been approved for furloughs prior to the pandemic, nor does it account for the possibility of alternative approaches to home visits that have been recognized around the country during the pandemic.[52] OJJ has the power at least to reinstate its policy to recommend

[49] *See* Defs.' Opp'n to TRO at 22 n.19 ('To the extent Plaintiffs are attempting to make a 'conditions of confinement' allegations, the liability test for such claims is whether 'a particular condition or restriction of pretrial detention is reasonably related to a legitimate governmental objective.''); *see also Bell v. Wolfish*, 441 U.S. 520, 539 (1979).
[50] *Bell*, 441 U.S. at 539.
[51] While Defendants claim that suspending the furlough program was an effort to reduce transfers, per CDC guidance, this argument is disingenuous, as many children have been transferred between OJJ facilities in the time since the furlough program was suspended. *See, e.g.*, Decl. of N.H., Dkt. 1-4 at ¶ 3; Decl. of L.P., Dkt. 1-7 at ¶ 3; Decl. of B.B., Dkt. 1-8 at ¶ 3; Ex. 2, J.P. Decl. at ¶ 6; Ex. 6, D.W. Decl. at ¶ 3-4.
[52] *See, e.g.*, States Modify Home Visiting Services in Response to COVID-19, (April 2, 2020), *available at* https://www.zerotothree.org/resources/3315-states-modify-home-visiting-services-in-response-to-covid-19.

youth for furlough,[53] and Defendants' affiant Shawn Herbert has admitted that '[i]n exceptional circumstances, an extended furlough can be recommended.'[54] Releasing detained or incarcerated individuals is widely recognized as a necessary measure to reduce the number of people housed together in congregate environments, thus facilitating social distancing, reducing the strain on medical systems near such populations, and saving lives.[55] According to Glenn Holt, former Deputy Assistant Secretary of OJJ, 'OJJ already knows who is furlough-eligible because it is discussed at every quarterly staffing meeting. They also already know who is eligible for early release and could have put into place a process to file motions to modify using specific criteria (such as SAVRY, offense, programming, etc.). In a matter of days, they could have had a prioritized list and started transferring kids home to keep both kids and staff safer.'[56] 'There is no question that requiring children to remain detained in congregate care facilities is more dangerous than the travel required to release children to their homes.'[57] And reducing the OJJ secure care

[53] Defendants' argument that OJJ does not have unilateral authority to release children is largely irrelevant. First, furloughs alone would significantly decrease the strain on OJJ's facilities. Although a furlough has to be approved by a judge, OJJ is not even attempting to seek such approval. OJJ could, for example, put a child on furlough until his release date 90 days in the future. The child would still be in OJJ custody and could easily be returned to the facility if there were a problem, and if OJJ focused on children who are near release and could be furloughed until their disposition terminates, there would be no need for the children to return to the facility afterward. Second, the consent of district attorneys is not required for modification; they can object, but their affirmative authorization is not required, and the possibility of objection does not prevent OJJ from seeking modification. *See* La. Ch.C. Art. 910 and 911. Finally, Defendant Governor Edwards has the power to release individuals during a state of emergency under La. R.S. § 29:722. *See* Letters to Governor Edwards, Dkt. 1-11 at 7-8.

[54] Herbert Decl., Dkt. 25-5 at 4, ¶ 17.

[55] Responses to the COVID-19 pandemic, *Prison Policy Initiative*, https://www.prisonpolicy.org/virus/virusresponse.html (last visited May 26, 2020) ('Massachusetts jails in [certain] counties have reduced their populations by around 20%. County jails in Colorado and Florida are reporting population decreases by over 30% in the past few months. On May 19th, a federal judge ordered the federal Bureau of Prisons to 'expedite the release' of 837 people. . . . Since March 10th, the Cuyahoga County [Cleveland, Ohio] jail has released about 900 people, reducing its population by more than 30%. . . . The Northwestern Regional Adult Detention Center in Virginia has reduced the jail population by about 20% from the daily average of the past 5 years.').

[56] Ex. 7, Supp. Holt Decl. at ¶ 14.

[57] Graves Decl., Dkt. 1-2 at ¶ 10; *see also* Ex. 8, Franco-Paredes Decl. at ¶ 25 ('[A]llowing these young individuals to reside with their parents or guardians would provide them with a safer living environment during this severe pandemic.'); Ex. 3, Maraynes Decl. at ¶ 12 ('If children were home with their parents, their parents would by definition constantly monitor their child for symptoms.').

population would also help maintain the required staff-to-youth ratio in the facilities, avoiding the need to bring in probation and parole officers, whose dangerous tactics have no place in OJJ's rehabilitative facilities. Defendants failed to release even those children they identified as having 'underlying medical conditions at increased risk of contracting COVID-19' due to unnamed 'subsequent disciplinary incidents.'[58] Defendants have proved themselves to be more concerned with discipline and rigidly enforcing their policies than with adapting to save children's lives.

Failing to administer COVID-19 tests to children living in a congregate environment, where positive cases have already been confirmed, serves no legitimate purpose and unconscionably exposes children to an increased risk of infection and transmission,[59] especially since new cases among OJJ staff have been confirmed as recently as May 26.[60] Defendants admit that '[t]he overwhelming majority of people who contract COVID-19 experience no symptoms of the disease or only mild symptoms' and that '[t]his is especially true with younger populations.'[61] COVID-19 patients can also present with lesser-known symptoms that will escape detection by simply screening for temperatures or coughs.[62] Defendants claim that their practice of not testing children who do not display specific symptoms is in line with CDC guidance, but that claim is

[58] Defs.' Opp'n to TRO at 8.

[59] OJJ's failure to test children creates an unconstitutional 'increased risk of infection.' Courts have deemed the first prong of the Eighth Amendment's test—an objective element, like the Fourteenth Amendment test—satisfied where the plaintiff has identified a factor responsible for either increasing the risk of contraction or the severity of infection. *See, e.g.*, *Owens v. Trimble*, No. 1:11-cv-01540-LJO-MJS (PC), 2012 U.S. Dist. LEXIS 73292, at *6 (E.D. Cal. May 24, 2012) ('An increased risk of infection may rise to a serious medical need and satisfy the first prong of the Eighth Amendment analysis.'); *see also Plata v. Brown*, No. C01-1351 TEH, 2013 U.S. Dist. LEXIS 90669, at *37 n.10 (N.D. Cal. June 24, 2013) (finding that certain medically groups are at an increased risk of harm from Valley Fever infection and should therefore be excluded from certain prisons).

[60] OJJ COVID-19 Information, La. Office of Juvenile Justice, https://ojj.la.gov/ojj-covid-19-information/ (last visited May 26, 2020) (listing 48 confirmed cases among staff); *see also* Ex. 8, Franco-Paredes Decl. at ¶ 20 ('[W]hen viral tests are conducted among all or most of detainees, these outbreaks are in fact much more extensive.').

[61] Defs.' Opp'n to TRO at 7.

[62] Vassallo Decl., Dkt. 1-5 at ¶ 8; *see also* Ex. 3, Maraynes Decl. at ¶¶ 4, 9 (symptoms of COVID-19 and/or PIMS in children can also include rashes, conjunctivitis, red lips and tongue, gastrointestinal symptoms, chest pain, enlarged lymph nodes, low blood pressure, and rapid heart rate).

based on a single CDC guidance document that has not been updated since March 23 and ignores more recent guidelines.[63] As of May 3, over three weeks ago, the CDC had published guidelines for testing clarifying that, while people *with* symptoms are 'high priority' for testing, people *without* symptoms are also a priority when there has been 'known exposure to an individual who has tested positive' or 'the occurrence of . . . transmission within a specific setting/facility.'[64] The CDC further states, 'Another population in which to *prioritize testing of* minimally symptomatic and *even asymptomatic persons* are *long-term care facility residents*, *especially in facilities where one or more other residents have been diagnosed* with symptomatic or asymptomatic COVID-19.'[65] This more up-to-date CDC guidance plainly indicates that OJJ's secure care facilities, where the children are long-term residents and where other residents have been diagnosed with COVID-19, are populations in which to prioritize testing of minimally symptomatic and asymptomatic persons. Indeed, recent instances of mass testing in Louisiana have revealed that many cases of COVID-19 among people who are incarcerated are asymptomatic.[66] Without knowing how many children have the disease, OJJ cannot implement proper isolation protocol, contact tracing and

[63] *See* CDC, 'Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities' (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidancecorrectional-detention.html.

[64] CDC, Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19), https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html (last visited May 26, 2020).

[65] *Id.* (emphases added).

[66] *See, e.g.*, WDSU Digital Team, *Majority of COVID-19 cases in Louisiana prisons that mass test are asymptomatic*, WDSU NEWS (May 22, 2020), https://www.wdsu.com/article/majority-of-covid-19-cases-in-louisiana-prisons-that-mass-test-are-asymptomatic/32634504 ('Louisiana's prison system this week began 'mass testing' at a second state correctional facility. The results show two-thirds of inmates who contracted COVID-19 between two prison facilities the agency considers 'hot spots' tested positive without showing symptoms.'); Janet McConnaughey, *Most women in 1 Louisiana prison dorm have COVID-19*, ASSOCIATED PRESS (May 6, 2020) https://apnews.com/f31d0a19272193a0f461eb96e5c3d23d (155 incarcerated women who displayed *no symptoms* were tested at Elayn Hunt Correctional Center, and an incredible 117—over 75%—tested positive.).

containment, or appropriate medical monitoring.[67] For these reasons, in part, federal courts are recognizing the importance of mass testing in prisons.[68]

Using a Behavioral Intervention ('BI') Room as a medical isolation room also serves no legitimate purpose and unnecessarily exposes children to serious trauma. These rooms are not designed to house sick or recovering children for days at a time; they are 'only intended to be used for very short periods of time for children whose behavior is out of control and pose an imminent harm to others.'[69] Using BI Rooms for medical isolation is equivalent to using solitary confinement for medical isolation, a widely-condemned practice.[70] When Plaintiff-Petitioner I.B. was put in a BI Room after he tested positive for COVID-19, he reported that it was dirty and had no air conditioning.[71] He had no access to running water for two or three days, was unable to bathe or brush his teeth during that time, and received no medical attention.[72] As Glenn Holt states, 'There

[67] Ex. 3, Maraynes Decl. at ¶ 10 ('Once a child starts demonstrating symptoms of shock, the current guidelines would be to get three fluid boluses and antibiotics into the patient within the first hour.').
[68] *See, e.g.*, *United States v. Pabon*, No. 17-165-1, 2020 U.S. Dist. LEXIS 78245, at *9 (E.D. Pa. May 4, 2020) ('Correctional facilities that have made the decision to undertake mass testing have discovered dramatically higher numbers of infected inmates than previously imagined. . . . Without mass testing . . . the Court may be getting a false picture.'); *see also United States v. Salley*, No. 19-688, 2020 U.S. Dist. LEXIS 87373, at *17-18 (E.D. Pa. Apr. 28, 2020) ('Mass testing recently undertaken in state jails and prisons reveals the rapid and insidious spread of COVID-19, particularly among asymptomatic incarcerated people.'); *United States v. Mattingley*, No. 6:15-cr-00005, 2020 U.S. Dist. LEXIS 85935, at *9 n.6 (W.D. Va. May 14, 2020) ('[T]he Court [cannot] ignore evidence tending to show that testing may be insufficient in many BOP facilities, either to provide an accurate representation of current cases or to ensure inmate safety in the event of an outbreak.'); *Wilson v. Williams*, No. 4:20-cv-00794, 2020 U.S. Dist. LEXIS 87607, at *3 (N.D. Ohio May 19, 2020) (noting 'the obvious need for rapid implementation of mass testing'); *Barbecho v. Decker*, No. 20-cv-2821 (AJN), 2020 U.S. Dist. LEXIS 86350, at *15 (S.D.N.Y. May 15, 2020) ('[P]risons conducting aggressive testing are finding that infection is spreading quickly.') (internal quotation marks omitted).
[69] Ex. 7, Supp. Holt Decl. at ¶ 19 ('OJJ policy requires they be removed from these cells as soon as their behavior no longer poses a threat to others.').
[70] *See generally* David Cloud, Dallas Augustine, Cyrus Ahalt, & Brie Williams, AMEND, The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings (Apr. 9, 2020), *available at* https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.
[71] A.B. Decl., Dkt. 1-10 at ¶ 8 ('After my son tested positive for COVID-19, they put him in a dirty room at Cypress with no air conditioning. He was in there without water for 2-3 days. There were other children with him who had tested positive for COVID.'); *see also* Holt Decl., Dkt. 1-9 at ¶ 13 ('The Cypress disciplinary wing at the Swanson Center for Youth at Monroe was shut down in 2005 and turned into a short-term crisis intervention unit. They are currently using it for suicide watch as well as reconstituted it as disciplinary lockdown unit.').
[72] A.B. Decl., Dkt. 1-10 at ¶¶ 8, 9, 11.

is no reason that [OJJ] should be putting any children in the BI cells. Those cells are punitive and problematic for children's mental well-being (especially if used for prolonged periods of time). . . . The BI cells should not be part of any medical isolation plan, particularly for kids who are recovering from COVID-19.'[73] Defendants' Opposition does not address the relief Plaintiffs seek regarding the use of BI Rooms for medical isolation. That silence speaks volumes.

While structured education and rehabilitative programming must be adapted to the pandemic, the severe restrictions Defendants put in place serve no legitimate purpose and prevent rehabilitation, the sole purpose of OJJ custody.[74] Defendants admit that children are confined to their dorms 'at all times.'[75] Defendants' vague references to 'worksheets,' 'online assignments,' and 'access to . . . software' are hardly evidence of adequate programming.[76] Rehabilitation services are meant to be individualized, with progressive goals and benchmarks.[77] While it is true that education systems everywhere are being forced to adapt, programming takes on a heightened level of importance when children are trapped in their dorms with nothing to occupy their time. Moreover, the express *purpose* of Plaintiffs' confinement is rehabilitation; therefore, in light of

[73] Ex. 7, Supp. Holt Decl. at ¶ 19. OJJ has estimated that approximately 44% of children in secure care have serious mental illness. Oversight of Rehabilitation and Treatment in Secure Care Facilities, Office of Juvenile Justice (June 13, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/$FILE/000194C2.pdf.

[74] 'Rehabilitation requires meeting the needs of kids identified in their individual assessments to the best of your ability.' Ex. 7, Supp. Holt Decl. at ¶ 16.

[75] Defs.' Opp'n to TRO at 10.

[76] *Id.* at 28.

[77] OJJ employs the 'LA MOD' program for every child in its custody, which focuses on individualized services and goal-setting, group and circle work, and family involvement. There are four progressive levels that a child can achieve through the program, most of which depend on group development. OJJ has provided no evidence that any child has been able to move up in levels since the lockdowns began two months ago, which is evidence that the current programming is insufficient to constitute rehabilitation. YS Policy No. B.2.7, *available at* https://ojj.la.gov/wp-content/uploads/2017/09/A.2.7-1.pdf. Even before the pandemic, OJJ had been critiqued by the Louisiana Legislative Auditor for, among other things (1) not having a formalized, evidence-based curriculum and not offering an array of evidence-based programs for the approximately 65% of children housed in general population dorms, and (2) not consistently documenting group therapy sessions and not collecting program participation and completion data for children in specialized treatment programs or vocational programs. Oversight of Rehabilitation and Treatment in Secure Care Facilities, Office of Juvenile Justice (June 13, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/ $FILE/000194C2.pdf.

Defendants' concession that rehabilitative services are currently necessarily limited, there is no justification for Plaintiffs' continued detention.

In short, none of the OJJ actions targeted by Plaintiffs' TRO request are rationally related to legitimate governmental purposes;[78] all frustrate the governmental objectives of health, safety, and pandemic control by exposing children to increased and unnecessary risks of harm and trauma.

C. Even under the Eighth Amendment Standard, Defendants Are Violating Plaintiff-Petitioners' Rights Because the Subjective Element of the Deliberate Indifference Test Is Satisfied

Even under the Eighth Amendment standard, which requires an additional element of subjective intent, the evidence demonstrates that Defendants are violating Plaintiffs' constitutional rights because they are—and have been—aware that they are creating unsafe conditions and have failed to remedy those defects.[79] The Eighth Amendment standard for children is more protective than the standard for adults.[80] Conditions may amount to an unconstitutional risk of harm for youth when they would be constitutional for adults; similarly, Defendants have an obligation to be aware of risks to youth when they would have no such obligation for adults. The dire risks of COVID-19, and the recommended means of mitigating those risks, are 'obvious,'[81] and there is now a high

[78] Pepper spraying children also serves no legitimate purpose, exposes children to serious physical harm, and inflicts unnecessary trauma. Defendants incorrectly assert that the April 27 memorandum from Interim Deputy Secretary Bickham 'prohibited the carrying of chemical/pepper spray within OJJ's secure care facilities.' Defs.' Opp'n to TRO at 13. The memorandum expressly carves out an exception to the prohibition: 'unless given specific directives from the Regional Director for a specific incident.' Memorandum from E. Dustin Bickham to OJJ Staff (Apr. 27, 2020), Dkt. 7-4. '[E]xposure even to minimal concentrations [of pepper spray]. . . would predispose [children] to nasopharyngeal mucosa irritation that could facilitate novel coronavirus infection and . . . may lead to more severe clinical manifestations of COVID-19.' Ex. 8, Franco-Paredes Decl. at ¶ 23.

[79] *See Farmer v. Brennan*, 511 U.S. 825, 828 (1994); *see also, e.g., Braggs v. Dunn,* 257 F. Supp. 3d 1171, 1250 (M.D. Ala. 2017) ('To establish deliberate indifference, plaintiffs must show that defendants had subjective knowledge of the harm or risk of harm, and disregarded it or failed to act reasonably to alleviate it.').

[80] *See See Roper v. Simmons,* 543 U.S. 551 (2005) (holding the death penalty violates the Eighth Amendment for children even though it is constitutional for adults because, as a class, youth are less culpable, more impulsive, and more susceptible to change); *Graham v. Florida,* 560 U.S. 48 (2010) (holding certain life without parole sentences unconstitutional as applied to youth even when constitutional for adults for the same reasons).

[81] '[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.' *Gates v. Cook*, 376 F.3d 323, 333 (5th Cir. 2004); *see also Cameron v. Bouchard*, 20-cv-10949, Dkt. 93 at 51 (E.D. Mich. May 21, 2020) (finding that the subjective component of deliberate indifference was satisfied because

level of public awareness that patients can be asymptomatic and that mass testing is necessary to fully identify the prevalence of infection, particularly after an outbreak has been identified in a congregate care setting.[82] Moreover, Defendants have expressly been put on notice that their response is both inadequate and dangerous. Advocates sent letters to Governor Edwards regarding the prevention and management of COVID-19 in OJJ's secure care facilities—he never responded, and none of those recommendations have been implemented.[83] Additionally, parents have been contacting Defendants frequently with desperate concerns about their children's well-being.[84]

Moreover, 'correctional officials have an affirmative obligation to protect inmates from infectious disease.'[85] The Fifth Circuit has repeatedly recognized that, even in normal times, unreasonably subjecting detained people to infectious disease constitutes deliberate indifference.[86] The evidence indisputably establishes that Defendants' COVID-19 response is egregiously unsound and poses increasingly grave, unconstitutional dangers to the children in OJJ custody.

IV. Plaintiffs Will Suffer Irreparable Injury Absent Emergency Relief

Defendants' argument that Plaintiffs are not suffering irreparable harm ignores the most relevant case law. In the context of infectious disease, it would not matter, for the purposes of

---

'the danger COVID-19 poses . . . is practically common knowledge. . . . the CDC's guidance on how to curb the spread of coronavirus . . . has been the topic of extensive national and local media coverage. . . . [and] Defendants took an immediate and proactive response to the COVID-19 pandemic to curb an outbreak').

[82] *See supra*, note 68.

[83] *See* Letters to Governor Edwards, Dkt. 1-11.

[84] *See, e.g.*, A.B. Decl., Dkt. 1-10 at ¶ 6 ('[I] told [my son's case worker's supervisor] that I was worried that my son was in danger. . . . I told him I was worried that the boy who used the phone after my son had gotten the virus from him. . . . I told him they should test everybody in the facility.').

[85] *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996).

[86] *See, e.g.*, *Gomez v. Warner*, 39 F.3d 320 (5th Cir. 1994) (per curiam) (prisoner alleged deliberate indifference by prison officials where the prison's razor-swapping program created the mere 'risk' of 'possible spread' in the transmission of deadly 'infectious diseases such as HIV, AIDS, and hepatitis.'); *Johnson v. Epps*, 479 F. App'x 583, 589-92 (5th Cir. 2012) (allegations that inmate was exposed to 'serious, communicable diseases' and that prison officials were aware of the risk and did nothing to prevent it were sufficient to state a claim for violation of Eighth Amendment rights); *Gates v. Collier*, 501 F.2d 1291, 1300-03 (5th Cir. 1974) (affirming district court's holding that allowing '[s]ome inmates with serious contagious diseases . . . to mingle with the general prison population,' alongside maintaining a host of other unsanitary and inhumane conditions, 'constitute[d] cruel and unusual punishment').

irreparable harm, if not a single child in OJJ custody had yet contracted COVID-19. The Eighth Amendment 'require[s] a remedy' where jailors knowingly expose their charges to a risk of contracting serious infectious diseases, even if 'it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed.'[87] Here, 28 children have already tested positive, and it is highly likely that many more are asymptomatic.

Additionally, independent of the health risks of COVID-19, every day that children are confined in OJJ custody without sufficient programming to provide rehabilitative services contravenes the purpose of their detention and violates their Fourteenth Amendment rights.

V. Defendants Will Not Be Harmed by the Relief Sought, and the Public Interest Will Be Served

Despite Defendants' suggestions to the contrary, the requested relief would actually lessen the burden on OJJ and better protect its staff. Furloughs or releases would mean fewer children to care for, which would help maintain an appropriate staff ratio without an over-reliance on probation and parole officers who are not appropriately trained to work with children in OJJ facilities. Providing appropriate structured programming would also not overly burden Defendants. Other juvenile justice facilities have adapted their curricula to a virtual setting,[88] just as schools and universities in the outside community have been forced to do. Finally, OJJ already has as many as 150 COVID-19 tests and would not be unduly burdened by administrating those tests to children—or by requesting additional tests. Identifying all positive cases among the children would allow the facilities to implement appropriate releases, isolations, and quarantines and reduce the risk of transmission to other children and to staff. OJJ cannot simply ignore the

[87] *Helling v. McKinney*, 509 U.S. 25, 33 (1993).
[88] *See, e.g.*, Ex. 7, Supp. Holt Decl. at ¶ 8 ('During this pandemic, we are able to maintain educational services in Arkansas because we use online schooling called Virtual Arkansas. This allows the children to continue to receive individualized educational services and allows those who are on-track to continue to progress timely towards getting their high school diploma or GED, while maintaining social distancing.').

possibility of rampant infection by refusing to test in order to keep the number of confirmed cases artificially low. This reckless tactic audaciously contravenes the public interest.

Moreover, as Defendants acknowledge, '[t]he first two [TRO] factors are most critical.'[89] Because Plaintiffs are likely to succeed on the merits and suffering irreparable, ongoing injury that threatens their lives, emergency relief is warranted.

CONCLUSION

For all these reasons, Plaintiffs respectfully request that this Court grant their motion for temporary restraining order.[90]

Respectfully submitted this 27th day of May, 2020.

/s/ Mercedes Montagnes

Mercedes Montagnes, La. Bar No. 33287
Nishi Kumar, La. Bar No. 37415
Rebecca Ramaswamy**
The Promise of Justice Initiative
1024 Elysian Fields Avenue
New Orleans, LA 70117
Telephone: (504) 529-5955
Facsimile: (504) 595-8006
Email: mmontagnes@defendla.org

Marsha Levick, *pro hac vice*
Jessica Feierman*
Karen U. Lindell*
JUVENILE LAW CENTER
1800 JFK Boulevard, Suite 1900A
Philadelphia, PA 19103
Telephone: (215) 625-0551
Email: mlevick@jlc.com

Stuart Sarnoff, *pro hac vice*
Lisa Pensabene**
Laura Aronsson, *pro hac vice*
Mariam Kamran, *pro hac vice*
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, NY 10036
Telephone: (212) 326-2000
Email: ssarnoff@omm.com

Brandon Amash, *pro hac vice*
O'MELVENY & MYERS LLP
610 Newport Center Drive
17th Floor
Newport Beach, CA 92660
Telephone: (949) 823-6900
Email: bamash@omm.com

John Adcock

Benjamin Singer, *pro hac vice*

[89] Defs.' Opp'n to TRO at 14 (citing *Barber v. Bryant*, 833 F.3d 510, 511 (5th Cir. 2016)).

[90] If the Court believes that the factual findings and recommendations of an epidemiology expert with extensive experience evaluating correctional facilities stricken by COVID-19 would be helpful, Dr. Franco-Paredes is available and willing to do a site inspection of any or all of the OJJ facilities. Ex. 8, Franco-Paredes Decl. at ¶ 26.

La. Bar No. 30372
Adcock Law LLC
3110 Canal Street
New Orleans, LA 70119
Telephone: (504) 233-3125
Email: jnadcock@gmail.com

David Lash, *pro hac vice*
O'MELVENY & MYERS LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071
Telephone: 213-430-6000
Email: dlash@omm.com

Jason Yan, *pro hac vice*
O'MELVENY & MYERS LLP
1625 Eye Street, NW
Washington, DC 20006
Telephone: (202) 383-5300
Email: bsinger@omm.com

Attorneys for Plaintiffs

**Pro hac vice* pending
***Pro hac vice* to be submitted

CERTIFICATE OF SERVICE

I, Nishi Kumar, an attorney, hereby certify that on May 27, 2020, I caused a copy of the foregoing to be filed using the Court's CM/ECF system.

I further certify that I, or another one of Plaintiffs' attorneys, will promptly electronically serve a copy of the same, along with all other pleadings and papers filed in the action to date to the General Counsel for the Louisiana Office of Juvenile Justice, the General Counsel for the Louisiana Governor, and the Louisiana Department of Justice Director of Litigation via email.

/s/ *Nishi Kumar*
Nishi Kumar, La. Bar No. 37415

Chronic Care as of May 22, 2020

Name	***Jets***	***Problem***	***Site***
N.D.		Hemophilia	SCY -Columbia
T.F.		IgA Nephropathy/ Hypertension	SCY -Columbia
E.D.		Asthma	SCY -Columbia
J.M.		Seizure	SCY -Columbia
Z.J.		Seizure	SCY -Columbia
D.F.		GI resection post Gun Shot Wound	SCY -Monroe
T.B.		Seizure	SCY -Monroe
J.M.		Asthma	BRDGE CITY
E.M.		Asthma	BRDGE CITY
N.B.		Hypertension	BRDGE CITY
J.B.		Diabetes	BRDGE CITY
A.W.		Hypothyroid	BRDGE CITY
J.L.		Lupus	BRDGE CITY
E.A.		Asthma	ACY
J.W.		Asthma	ACY
D.S.		Asthma	ACY
J.T.		Hypertension	ACY

DECLARATION OF J.P.

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

1. My initials are J.P.
2. I am at least 18 years of age and am competent to make this declaration.
3. My son D.M. is being held at Swanson Center for Youth in Monroe, LA. His release date is October 14, 2020. He is trusted within the facility and helps do a lot of yard work around Swanson and outside the facility.
4. My son is furlough-eligible and has previously come home on furlough many times since March of 2019. He was home on furlough in January, February, and March. We normally do furloughs as often as we can. In March, he was home on furlough from March 12 to 17 but OJJ made him go back to Swanson early on March 16 because of the pandemic. When he went back to Swanson, all they did was take his temperature. I was planning on asking for furloughs over the next three months before COVID-19. It is my understanding furloughs have been suspended by OJJ indefinitely.
5. My son is in a dorm with at least eight other children. None of them have been tested for COVID-19 that my son is aware of, even though there are other people in the facility – staff and children – who tested positive for COVID-19. There was at least one child in his dorm with a fever that was never tested for COVID-19 and was not removed from the dorm. The distance between the beds in the dorms is unchanged. The children are not able to practice social distancing and are not being told not to interact with each other or staff. My son has had one mask during this whole pandemic, but has not been told to wear it. He wore it during his Zoom court hearing on early May and has not put it back on since. He doesn't have a mask on when I do Zoom conference calls with him. He has small amounts of hand

sanitizer but it does not have any alcohol in it so it is not a disinfectant. They just recently started disinfecting objects a few times a day.

6. Swanson is extremely understaffed and this week they moved some children from other facilities to Swanson, including children who tested positive COVID-19 positive at Swanson Columbia. Those children were put in Holly dorm and housed there. My son saw at least one child who was very sick. Staff is working 18-hour days and they are not receiving any overtime.
7. I have called OJJ to try to get information on my son and what policies they have around COVID-19 and was told by someone at Swanson that they could not release any information to me. I also sent Shawn Herbert, the director of Swanson Monroe, a letter, which she never responded to. I sent that letter after children were moved to Swanson from Bridge City. I was worried about my son's health and wellbeing. I spoke to the regional director about my concerns.
8. My son is not provided with any educational services or other programming, including trade programming. He was previously doing welding training and taking a college course online. Children in his dorm were going through the JUMP program that is required by most judges and they are no longer able to participate in that program. His dorm is regularly not permitted outside for 4 to 5 days at a time. Now when they go anywhere, it is to a dirty, poorly ventilated gym that is not cleaned between different dorms using it and has no air flow. I am worried about the risk of infection. Children from Bridge City and some of the children who tested positive were put into solitary confinement in Cypress. My son does not want to get sick and have to be housed there.
9. I have not been able to visit my son since he went back to Swanson on March 16. Normally I visit him on both Saturdays and Sundays every week. My husband and I spend the night in

Monroe every weekend so that we are able to visit with him both days. I have had some Zoom calls. My son had a Zoom court date in early May but otherwise has not had access to his attorney. He tried to call the attorneys litigating this case on May 19, 2020, and was not allowed to do so because of OJJ restrictions on who he is allowed to call on the phone.

10. I would like my son to come home on furlough until all COVID-19 is absent from the facility and everyone has been tested and there is a vaccine. There is no reason for him to be detained right now. He is not receiving any rehabilitative services. He was a mentor to a lot of children through the Kiros Torch program and that has been suspended indefinitely. That program makes a big difference in the children's lives. There is no Bible study or church services. It is very important to my husband and I that our son is able to practice his religion. My ability to parent him is being impeded by the fact that he is in a facility and away from me. He has a safe home to come home to.
11. As a named plaintiff, to the best of my ability, I have been working with my lawyers to help them prepare and work on this case. I will continue to do so. I am available to them to assist with the case, and they are available to me to answer questions and to explain and keep me updated on the litigation. I regularly speak with my attorneys and their staff to provide them information in support of this lawsuit. I have responded and will continue to respond to the lawyers' requests for information about adequate health care and other conditions of confinement to the best of my ability. I intend to continue working zealously with my attorneys on behalf of the family members of other individuals detained in Louisiana as long as I am a named plaintiff.
12. I seek only declaratory and injunctive relief on behalf of the class. I am not seeking monetary damages, and I understand this this civil case will not result in the dismissal of any criminal proceedings against my son or others.

13. I have authorized my attorney to sign on my behalf given the difficulty of arranging visitation and travel due to the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.
14. This declaration was read to me in English and I was able to make changes and corrections.

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

Signature:

/s/ Nishi Kumar
Nishi Kumar on behalf of J.P.
May 20, 2020

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

1. I am a licensed attorney in good standing in Louisiana.
2. I represent the declarant J.P. Out of necessity in light of the COVID-19 pandemic, I signed the attached declaration on her behalf with her express consent.
3. I spoke with J.P. over the phone. She has confirmed that I can sign on her behalf as reflected in her declaration.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge and that this declaration was executed on May 20, 2020 in New Orleans, Louisiana.

Signature:

/s/ Nishi Kumar
Nishi Kumar
May 20, 2020

DECLARATION OF DR. MEGAN MARAYNES CONCERNING THE RISK OF COVID-19 IN THE OFFICE OF JUVENILE JUSTICE'S SECURE FACILITIES

I, Dr. Megan Maraynes, declare as follows:

1. I completed my Bachelor of Science at Cornell University, and earned my medical degree from St. Georges University in Grenada. I completed my internship and residency in Pediatrics at Jacobi Medical Center / Albert Einstein College of Medicine in the Bronx, New York, and my fellowship in Pediatric Emergency Medicine at Kings County Hospital Center / SUNY Downstate College of Medicine in Brooklyn, New York, where I served as Chief Education Fellow. I have worked in a Louisiana pediatric emergency room during the course of COVID-19 and have observed and treated COVID-19 patients during this time.

2. COVID-19 is the disease associated with the novel coronavirus, SARS-CoV-2. The virus causes upper respiratory tract illness, and it emerged in Wuhan, China, in December 2019.[1] As of 8:32 AM CST on May 26, 2020, there are over 5.5 million cases worldwide, and nearly 350 thousand deaths.[2] In the United States, there are over 1.6 million cases, and nearly 100,000 deaths.[3] Of these totals, Louisiana accounts for nearly 38,000 cases, and 2,500 deaths.[4] These numbers are still rising.

3. The novel coronavirus is extremely contagious. One study based on the virus's replication in China found that the average case will likely infect between 3.8 to 8.9 others, with the median reproduction number being 5.7.[5] This is based on a traveling population in China before physical distancing standards were put into effect, but the contagiousness of the virus raises serious concerns about those living in congregate settings who are incapable of physical distancing and practicing CDC-recommended hygienic and protective measures.

4. The CDC lists the following as COVID-19 symptoms in children: Fever, cough, nasal congestion, sore throat, shortness of breath, fatigue, muscle or body aches, headache, poor appetite, nausea or vomiting, and diarrhea.[6] However, this is not an exhaustive list of all the symptoms a COVID-19 patient may present. I have observed that some COVID-19 patients experience none of these symptoms, while others test positive while presenting symptoms such as chest pain or abdominal pain.

---

[1] National Institute of Allergy and Infectious Disease (NIAID), Coronaviruses (May 19, 2020), https://www.niaid.nih.gov/diseases-conditions/coronaviruses

[2] Johns Hopkins University, COVID-19 Dashboard (May 26, 2020), https://coronavirus.jhu.edu/map.html

[3] Johns Hopkins University, COVID-19 Dashboard (May 26, 2020), https://coronavirus.jhu.edu/map.html

[4] Louisiana Department of Health, Louisiana Coronavirus (COVID-19) Information (May 25, 2020), http://ldh.la.gov/coronavirus/

[5] Steven Sanche et al., High Contagiousness and Rapid Spread of Severe Acute Respiratory Syndrome Coronavirus 2, Emerging Infectious Diseases (April 7, 2020), https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article

[6] CDC, Information for Pediatric Healthcare Providers on COVID-19 (May 20, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html

5. In my experience in the pediatric emergency department, we have approached the problem with a public health focus. Ever since the scarcity of testing stopped being a limiting factor for us, we have had a very low threshold for testing because of the variety—and sometimes total lack—of symptoms. We have screened anyone with any possible symptom in the emergency department. Anyone getting admitted to the hospital for a planned elective procedure is tested. Anyone getting admitted for an unplanned procedure, such as treatment for a broken leg, is also tested.

6. Many have thought kids and adolescents to be mere vectors of the novel coronavirus—asymptomatic carriers who pose a threat to others, but who may not feel the effects of the virus themselves. This is not necessarily true. One study found that only 13% of pediatric cases presented no symptoms.[7] This figure may underrepresent the true proportion of cases where no symptoms accompany the virus' presence because asymptomatic carriers are less frequently tested than their counterparts who present symptoms, and consequently seek treatment.

7. The focus on children as asymptomatic carriers also overlooks the risk to kids with underlying illness, immune-deficiency, or obesity who are at risk for having a more severe COVID course. Although the risk overall of a child developing a severe case of COVID-19 is relatively low, it is a risk that should be taken seriously. A study out of the Montefiore Children's Hospital found that 28% of pediatric cases required intensive care.[8]

8. There is also the risk that children who contract COVID-19 will develop pediatric inflammatory multisystem syndrome (PIMS, elsewhere referred to as MIS-C—multisystem inflammatory syndrome in children). The World Health Organization (WHO) has characterized it as an "acute illness accompanied by a hyperinflammatory syndrome, leading to multiorgan failure and shock."[9] Cases have been reported in the United States, Italy, France, Switzerland, and the United Kingdom.[10] The CDC has issued an emergency alert regarding

---

[7] Yuanyuan Dong et al., Epidemiological Characteristics of 2143 Pediatric Patients With 2019 Coronavirus Disease in China, Pediatrics (May 1, 2020). https://pediatrics.aappublications.org/content/early/2020/03/16/peds.2020-0702.1

[8] Jerry Y. Chao et al., Clinical Characteristics and Outcomes of Hospitalized and Critically Ill Children and Adolescents with Coronavirus Disease 2019 (COVID-19) at a Tertiary Care Medical Center in New York City, The Journal of Pediatrics (May 6, 2020), https://doi.org/10.1016/j.jpeds.2020.05.006

[9] World Health Organization, Scientific Brief: Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19 (May 15, 2020), https://www.who.int/news-room/commentaries/detail/multisystem-inflammatory-syndrome-in-children-and-adolescents-with-covid-19.

[10] T.R. Hennon et al., COVID-19 associated Multisystem Inflammatory Syndrome in Children (MIS-C) guidelines; a Western New York approach, Progress in Pediatric Cardiology (2020), https://doi.org/10.1016/j.ppedcard.2020.101232

the syndrome.[11] My emergency department has seen six or seven children presenting with PIMS, in addition to the eleven who have presented at Children's Hospital in New Orleans.[12]

9. The symptoms are multisystem, so the clinical diagnostic criteria checks for fever, conjunctivitis, red lips, gastrointestinal symptoms, red lips, and red tongue, low blood pressure, and/or rapid heart rate. Otherwise, it shows up as non-specific symptoms and could be confused with a host of other things, including allergies. The only smart way to discern allergy symptoms from COVID-19 or PIMS is to test the patient for the COVID antigen (in the case of acute infection), COVID antibodies (to indicate previous infection), or lab findings characteristic of PIM-S. Anyone with any symptom could be coming down with COVID-19 or PIMS, so we truly do not know who is at risk of developing this dangerous illness.

10. These patients we have seen have needed a broad array of cardiology and critical care services such as lab work to check inflammatory markers, fluid resuscitation, antibiotics, and vasopressor support if they face heart failure. Treatment for this syndrome is very similar to treatment for shock. Once a child starts demonstrating symptoms of shock, the current guidelines would be to get three fluid boluses and antibiotics into the patient within the first hour.[13] It is impossible at this point to say whether a symptom like a rash will progress to shock within a few hours or a few days. Speedy access to treatment, on the other hand, is absolutely imperative.

11. Moreover, asymptomatic children are not necessarily free from harm from PIMS. What we are seeing right now with PIMS is scary because it is clear that it is related to, and associated with, COVID-19. From my experience, a lot of the kids presenting PIMS test negative for COVID-19 initially but test positive for the antibody—indicating that a lot of them were asymptomatic carriers and are no longer shedding the virus. This means that there are seemingly healthy kids who could be at great risk of developing PIMS.

12. Given what little we know about PIMS, supervision of previously symptomatic pediatric patients for symptoms should extend after the three symptom-free day window currently recommended by the CDC.[14] It may be possible that a child could develop PIMS after appearing to be in the clear. If children were home with their parents, their parents would by

---

[11] T.R. Hennon et al., COVID-19 associated Multisystem Inflammatory Syndrome in Children (MIS-C) guidelines; a Western New York approach, Progress in Pediatric Cardiology (2020), https://doi.org/10.1016/j.ppedcard.2020.101232

[12] Emily Woodruff, There are 11 Louisiana cases of the pediatric inflammatory condition that's linked to coronavirus, NOLA.com (May 22, 2020), https://www.nola.com/news/coronavirus/article_cc495d86-9c55-11ea-bf78-87380aa2aa98.html

[13] Jenny Mendelson, Emergency Department Management of Pediatric Shock, Emergency Medicine Clinics of North America (May 5, 2018), https://doi.org/10.1016/j.emc.2017.12.010. The guidelines provide that "[f]luid administration in shock should be as rapid as possible," and to "administer broad-spectrum antibiotics within the first hour of presentation."

[14] CDC, Decision Memo: Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19 (May 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html

definition constantly monitor their child for symptoms. Any kid who has any possible PIMS symptoms should be monitored closely and tested appropriately.

13. I believe that OJJ's response to the pandemic does not follow best public health practices, and it endangers not only the children, but also staff and their families. Some children who tested positive or were suspected to have COVID-19 were originally brought from the Bridge City facility to our hospital in late March – one or two with mild respiratory symptoms and others with fevers and coughs. One of the doctors spoke to Ms. Matthews at Bridge City at that time and it sounded like they had no idea what to do with those kids and other kids who may have been exposed. We provided discharge instructions on how to properly medically isolate them but do not know if those were followed.

14. The juvenile justice setting is rife with opportunities of infection and spread. Cohorting children together may protect them from infection so long as testing is conducted before such cohorting happens. It makes no sense to cohort before or without testing, because an undetected infection can lead to many more very easily. Furthermore, these are not closed facilities: staff can bring the novel coronavirus into the facility and/or bring it home to their families and communities.

15. The infirmary in juvenile justice facilities may also provide opportunities for spread. It is likely that children will need the infirmary for non-COVID-19 related reasons. Children's presence in the infirmary puts them at risk of infection, and the reports that children are often asymptomatic carriers suggest that without testing, the children could put the infirmary staff at risk of infection, too.

16. For the OJJ to mitigate the spread of the coronavirus among Louisiana's incarcerated children are, I would recommend that they, at the very least, closely monitor ALL children and adolescents with ANY symptomatology, and liberally test all patients residing in these facilities for COVID, and implement cohorts based on these test results.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on May 26, 2020 in New Orleans, LA.

/s/ Megan Maraynes

Megan Maraynes

DECLARATION OF NISHI KUMAR

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

1. I represent the parents of I.B., a minor child.
2. I called Swanson Center for Youth at Monroe on May 8, 2020, in order to figure out who to send a Third-Party emergency grievance to via email. Staff at Swanson provided me with Ms. Herbert's email address.
3. I filed a Third-Party emergency grievance on behalf of I.B. on May 8, 2020 at 4:40 pm. I requested that the facility director, Shawn Herbert, or an appropriate party initially respond within 48 hours and respond within 5 days per OJJ's Administrative Remedy Procedure Act B.5.3.
4. I represent the parent of J.H., a minor child.
5. I called both Bridge City Center for Youth and Acadiana Center for Youth on May 9, 2020, in order to figure out who to send a Third-Party emergency grievance to via email. Staff at Acadiana provided me with Mr. Wood's email address. Staff at Bridge City told me they could not release that information over the phone.
6. I filed Third-Party emergency grievances on behalf of J.H. on May 9, 2020 at 5:34 pm and 5:37 pm. I requested that James Wood, Yamena Thompson, and Shannon Matthews, or an appropriate party respond initially within 48 hours and respond within 5 days per OJJ's Administrative Remedy Procedure Act B.5.3.
7. I received no acknowledgment of the abovementioned filings from OJJ or any other Defendants.

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

Signature

/s/ Nishi Kumar

Nishi Kumar

May 27, 2020

Nishi Kumar

From: Nishi Kumar
Sent: Saturday, May 9, 2020 5:37 PM
To: jameswood@la.gov
Subject: Emergency ARP on behalf of J.H.
Attachments: Emergency ARP on behalf of J.H. .pdf

Mr. Wood,

Attached please find an Third-Party Emergency ARP on behalf of J.H. . Kindly respond or have the appropriate party respond by email within 48 hours per OJJ's Administrative Remedy Procedure B.5.3. Out of necessity in light of the COVID-19 pandemic, I have signed the Third Party Acknowledgment/Approval Form on J.H. 's behalf, as authorized by his guardian. If you have any questions, you can reach me at 404-617-1467.

Best,

Nishi Kumar
Staff Attorney
The Promise of Justice Initiative
www.justicespromise.org
nkumar@defendla.org
504.529.5955

Follow us on Instagram, Twitter, & Facebook!

THE PROMISE OF JUSTICE INITIATIVE

Nishi Kumar

From: Nishi Kumar
Sent: Saturday, May 9, 2020 5:34 PM
To: Yamena.Thompson@LA.GOV; Shannon.matthews2@la.gov
Subject: Emergency ARP on behalf of J.H.
Attachments: Emergency ARP on behalf of J.H. .pdf

Ms. Thompson and Ms. Matthews,

Attached please find an Third-Party Emergency ARP on behalf of J.H. . Kindly respond or have the appropriate party respond by email within 48 hours per OJJ's Administrative Remedy Procedure B.5.3. Out of necessity in light of the COVID-19 pandemic, I have signed the Third Party Acknowledgment/Approval Form on J.H. 's behalf, as authorized by his guardian. If you have any questions, you can reach me at 404-617-1467.

Best,

Nishi Kumar
Staff Attorney
The Promise of Justice Initiative
www.justicespromise.org
nkumar@defendla.org
504.529.5955

Follow us on Instagram, Twitter, & Facebook!

THE PROMISE OF JUSTICE INITIATIVE

B.5.3 (a)

YOUTH SERVICES Number: _____-_____-_____

ADMINISTRATIVE REMEDY PROCEDURE FORM Date Received: 5/9/2020

Name: J.H. Client ID Number: 147597

Facility: Acadiana/Bridge City Center for Youth Living Area: _____

"THIS IS A REQUEST FOR ~~ARP~~" Emergency ARP

(You may ask your case manager or other staff members for help completing this form.) State your problem (WHO, WHAT, WHEN, WHERE AND HOW) and the remedy requested (what you want to solve the problem):

Problem: See Attached

Remedy requested: See attached

Date of Incident/Occurrence: March 13, 2020 to present Today's Date: 5/9/2020

This form must be completed within 90 calendar days of the date of the incident/occurrence and given to the ARP Coordinator or placed in the ARP/grievance box.

Screening - ARP Coordinator's Review

Rejected _____ Returned _____ Accepted Screening Date: _____ Sexual Assault □ Yes □ No

Reason: _____

Emergency Request

(Maximum Time for Processing – Initial Response: 48 hours / Final Response: 5 days)

Rejected: Accepted Reason: _____

Sent to Facility Director / Regional Director / IS on: _____

RD Initial Response Received on: _____ RD Final Decision Received on: _____

Step One - ARP Coordinator/IS Recommendation and Facility Director's Response

(Maximum Time For Processing: 30 calendar days)

ARP Coordinator/IS Recommendation: _____

Sent to Facility Director on: _____ AC/IS Signature: _____

Facility Director's response to your ARP Step One request: _____

Date: _____ Facility Director's Signature: _____

Received Step One on: _____ Youth's Signature: _____

If you are not satisfied with this response, you may go to Step Two. The ARP Coordinator must submit your request to the Deputy Secretary within 15 calendar days after you receive the Step One response.

Request Step Two: _____Yes _____No Reason for Step Two request: _____

Date Step Two request received by AC: _____ Date Sent to Deputy Secretary: _____

AC's Signature: _____

Step Two - Deputy Secretary's Response

(Maximum Time For Processing: 21 calendar days)

Date Received: _____

Deputy Secretary's response to ARP Step Two request: _____

Date: _____ _____
Deputy Secretary's Signature

Date received Deputy Secretary's response: _____ _____
Youth's Signature

If you are not satisfied with this response, you may seek judicial review. A request for judicial review must be filed with the juvenile court which entered your order of commitment within 30 calendar days after receiving the Step Two decision.

EMERGENCY ARP APPLICATION

May 9, 2020

Submitted On Behalf of J.H.

And All Others Similarly Situated

This is an Emergency ARP on behalf of J.H. .

I am an attorney representing J.H. 's parent and am filing this Emergency ARP as a Third Party on his behalf. The exigencies of this request arise directly from the national state of emergency resulting from the world-wide pandemic and wide-spread infection of many people from COVID-19.

J.H. is filing this emergency application on behalf of himself and all other similarly-situated youths in OJJ custody and housed in secure care facilities. J.H. is a minor child and currently is being held at the Acadiana Center for Youth (ACY). He was previously held at Bridge City Center for Youth and does not know when he will be transferred back.

The Problem:

The conditions under which J.H. are being held are medically dangerous and constitutionally defective. The following conditions of confinement represent an unwarranted and unlawful danger to him and to all others being so detained:

1. J.H. has been exposed unwillingly to the COVID-19 virus while in the custody of the Office of Juvenile Justice, Bridge City Center for Youth, and Acadiana Center for Youth. COVID-19 is a deadly viral pandemic. He, along with all others in OJJ custody and housed in the state's several secure care facilities, has been placed at an immediate risk of substantial harm.

2. At least ten youth and twenty-one staff members at Bridge City tested positive for COVID-19. At least one youth and one staff member at ACY has tested positive for COVID-19. J.H. has not been tested for COVID-19.

3. Both OJJ and the facility have a responsibility to take reasonable and accepted measures to keep J.H. safe and free from contagion while in OJJ custody. Measures recommended by the Center for Disease Control, as well as state and local governments, to help ensure safety have been violated by forcing J.H. (as well as the other children in custody) to live in the following conditions:

a. He is housed in a dorm with more than ten other youth. No testing has been done to determine if he, or others, are COVID-19 positive.

b. He is being denied access to his parent and family;

c. He is not being provided with personal protective equipment such as masks and adequate personal or other cleaning supplies;

d. He is being forced to live in a physical environment where recommended social distancing is impossible to maintain;

e. He is being subjected to inappropriate and excessive levels of discipline due to understaffing at the facilities during COVID-19. He has been pepper sprayed on multiple occasions by probation officers at both Bridge City and ACY. The use of pepper spray inside secure care facilities is not contemplated by the OJJ policy on interventions (Use of Interventions – Secure Care C.2.6). He was also transported between facilities for disciplinary reasons.

e. He is being denied during this national health emergency access to education, rehabilitative programming, counseling, recreation, and mental health treatment;

k. He is being denied the benefits of his Individualized Educational Plan.

These and other conditions of confinement constitute a violation of J.H. 's rights under state and federal law and the state and federal constitution, and the rights of all others being similarly confined.

The Remedy Sought:

J.H. , as well as every other person in OJJ custody and/or otherwise confined in secure care facilities throughout the state, are at immediate risk of substantial harm if continued confinement occurs under these dangerous conditions. Accordingly, the following remedies are requested:

a. He and all other youth in custody should be determined eligible for early release and should be released to the care of their families.

b. In the alternative, he and all other youth in custody should be deemed eligible for furlough and released home to their families until there is a vaccine for COVID-19, the facilities have been determined to be COVID-19-free, and the risk of infection from COVID-19 has been completely removed from the facilities.

c. If not released, he and all other youth in custody should be provided with appropriate PPE, personal cleaning and sanitizing supplies and materials, and the ability to practice socially distancing from those around him.

d. All those being confined in the secure care facilities, as well as all staff members and all others who enter the facilities, should be tested and frequently retested for COVID-19.

e. Staff must immediately cease using pepper spray and other disciplinary methods that place the youth in custody at risk of serious harm and are not in line with OJJ policy and practice.

e. He and all other youth in custody should be immediately provided with educational and rehabilitative programming in compliance with state and federal law and with any individual IEPs that he and others may have.

If rehabilitation is not being provided and constitutional conditions of confinement are not immediately put into place, there is no legal justification to continue to confine J.H. or any other child in a secure care facility.

The Response

Per the Office of Juvenile Justice's Administrative Remedy Procedure B.5.3, please respond within 48 hours to this Emergency ARP and provide a final decision within 5 days of filing.

Signature:

/s/ Nishi Kumar

Nishi Kumar

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

1. I am a licensed attorney in good standing in Louisiana.
2. I represent the parent of J.H. . Out of necessity in light of the COVID-19 pandemic, I was unable to obtain the signature of J.H. for the attached Third Party Acknowledgment/Approval Form. I am signing on his behalf, as authorized by the parent of J.H. . J.H. is a minor.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge and that this declaration was executed on May 9, 2020 in New Orleans, Louisiana.

Signature:

/s/ Nishi Kumar

Nishi Kumar

B.5.3 (d)

Administrative Remedy Procedure
Third Party Acknowledgment/Approval Form

I, J.H. _____ (Youth name), Client ID # 147597 _____,

due hereby agree/approve Nishi Kumar _____ to file an ARP
(Name of Third Party)

on my behalf. I understand that the above named third party is not my parent or legal guardian, and is acting in my best interest.

Nishi Kumar on behalf of J.H.	Katie Hunter-Lowrey
Youth Signature	Witness
May 9, 2020	May 9, 2020
Date	Date

DECLARATION OF D.W.

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

1. My initials are D.W.
2. I am at least 18 years of age and am competent to make this declaration.
3. My older son D.M.W. is being held at Bridge City Center for Youth. He was moved to Swanson Center for Youth in Monroe for a four or five days around April 21, 2020 and then was moved back to Bridge City. I didn't know either time that he was transferred until after he was transferred. His release date is July 30, 2020. His case worker told me he is eligible for early release. He is ready to come home and I am ready to have him home with me.
4. My younger son D.K.W. was also being held at Bridge City Center for Youth but he was moved to Acadiana Center for Youth around April 21, 2020. I didn't know that he was transferred until after he was transferred. His release date is in January 2021. He has told me he is eligible for early release. He is ready to come home and I am ready to have him home with me.
5. I was never informed by OJJ staff about the riot incident at Bridge City, and all I know is that it is under investigation. I tried to call someone at OJJ to figure out what is going on and they do not have any available to talk to me. I saw what happened on the news and D.M.W. told me children in his dorm were pepper sprayed by probation officers in the eyes. D.M.W. was pepper sprayed on his arm and his arm burned afterwards. I don't know if he received any medical treatment but I am very much hoping he did. He was transferred to Swanson shortly after that.
6. My older son D.M.W. had a fever and was tested for COVID-19 at the end of March or the beginning of April. He was then isolated in a solitary room for one or two days until his test came back negative. They just tested him once. I had to call his case worker to get that

information – it is not being provided to the young people or their parents. I am not able to get much information on my son's health.

7. My younger son D.K.W. has not been tested for COVID-19. Somebody in his dorm at Bridge City tested positive. The only people who could be giving the children COVID-19 would be the staff coming in and out of the facilities.
8. As far as I know, there is no process for reintroducing "recovered" children to the general population. At both Bridge City and ACY they were all in the dorm together and locked down 23 hours a day. There is no social distancing being practiced in the dorm. There are no policies around interactions with staff and other children. Sometimes they have masks and sometimes they don't. I don't know when they started giving the children masks. Staff doesn't make the children wear the masks. Staff are wearing masks, but not gloves.
9. There are no family or attorney visits allowed. I am allowed two calls a week with my sons. I am supposed to be getting a Zoom call with my older son.
10. All schooling and other developmental training has been suspended. Both of them were previously in regular school and trade school at Bridge City. They no longer have any access to school. They should have kept the children in school during the pandemic like they are with the children outside. They could have given them laptops so they could still be doing the work. They are not receiving any rehabilitation or other services that I know of.
11. D.K.W. was supposed to come home for his first furlough and the court had approved his furlough. It was cancelled after COVID-19 happened. I would like both my sons to come home on furlough until all COVID-19 is absent from the facilities, everyone has been tested, and there is a vaccine. There is no reason for either of them to be detained right now. They are not receiving any rehabilitative services. My ability to parent them is being impeded by

the fact that he are in a facility and away from me. I am very scared for them. I haven't been able to get any answers to my questions from OJJ. I just want to be able to hug my sons.

12. As a named plaintiff, to the best of my ability, I have been working with my lawyers to help them prepare and work on this case. I will continue to do so. I am available to them to assist with the case, and they are available to me to answer questions and to explain and keep me updated on the litigation. I regularly speak with my attorneys and their staff to provide them information in support of this lawsuit. I have responded and will continue to respond to the lawyers' requests for information about adequate health care and other conditions of confinement to the best of my ability. I intend to continue working zealously with my attorneys on behalf of other individuals detained in Louisiana and their family members as long as I am a named plaintiff.
13. I seek only declaratory and injunctive relief on behalf of the class. I am not seeking monetary damages, and I understand this this civil case will not result in the dismissal of any criminal proceedings against my sons or others.
14. I have authorized my attorney to sign on my behalf given the difficulty of arranging visitation and travel due to the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.
15. This declaration was read to me in English and I was able to make changes and corrections.

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

Signature:

/s/ Nishi Kumar
Nishi Kumar on behalf of D.W.
May 25, 2020

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

1. I am a licensed attorney in good standing in Louisiana.
2. I represent the declarant D.W. Out of necessity in light of the COVID-19 pandemic, I signed the attached declaration on her behalf with her express consent.
3. I spoke with D.W. over the phone. She has confirmed that I can sign on her behalf as reflected in her declaration.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge and that this declaration was executed on May 25, 2020 in New Orleans, Louisiana.

Signature:

/s/ Nishi Kumar

Nishi Kumar

May 25, 2020

SUPPLEMENTAL DECLARATION OF GLENN HOLT

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

1. I have 26 years of experience in senior level public administration and policy in the juvenile and criminal justice fields. I have worked for the government at the state, county/parish, and city level. I worked for the Louisiana Office of Juvenile Justice in its previous iteration from 2005 to 2009. I was the Director of the Swanson Center for Youth in Monroe from 2005 to 2007 and a Deputy Assistant Secretary of OJJ from 2007 to 2009. I then worked for the City of New Orleans from 2010 to 2016. I went back to work at OJJ in 2016 and was a Deputy Assistant Secretary/Assistant Secretary/Regional Director from 2016 to 2019. I am currently the Deputy Director for the Arkansas Division of Youth Services. I have also worked as a Treatment Manager for the Iowa Department of Corrections and the Director of the Polk County Juvenile Detention Center. I have been certified as a juvenile justice expert before courts in Louisiana. I have testified on behalf of the Iowa Department of Corrections in federal court.

2. I have first-hand knowledge of policy-making procedures at OJJ and the pandemic policy in particular. At OJJ, I have worked with facility directors to institute the Missouri model[1] that was mandated under a federal consent decree. I was responsible for writing policy and procedure at both the facility level and at the OJJ level. When I was Assistant Secretary, I drafted and approved policies and procedures and made edits to existing policies as necessary, including the emergency operations plan and the pandemic policy. I was the point of contact for the Department of Homeland Security. After the last major flu outbreak, I wrote the facility and agency policy for how we would respond to the next type of pandemic outbreak. It has been updated since, but I have reviewed the most recent version dated December 11, 2019,[2] and very little has changed from the version I drafted. In Arkansas, we updated our pandemic policy using the interim guidance specific to correctional facilities from the Centers for Disease Control ("CDC")[3] as well as guidance from the Arkansas Department of Health. We mandated that the companies we contract with that directly run the juvenile facilities update their policies in accordance with our updated policy. It does not appear that OJJ has updated its policies to implement the CDC guidance. For example, the facilities should be asking all staff and children a set of diagnostic questions about general health, including cough, fever, and other COVID-related symptoms on a daily basis. OJJ should be getting reports on all testing numbers from each facility. Any staff that has a temperature of 100 degrees or more should be denied entrance to the facility. If anyone has

[1] The Annie E. Casey Foundation, The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders, (Jan. 1, 2010), https://www.aecf.org/resources/the-missouri-model/
[2] Office of Juvenile Justice, Influenza Preparedness, Response and Recovery A.1.13, (December 11, 2019), *available at* https://ojj.la.gov/wp-content/uploads/2020/01/A.1.13.pdf.
[3] CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

traveled within the last 14 days, they should be denied entrance to the facility. If anyone has had contract with anyone with COVID or who has been suspected to have COVID, they should be denied entrance to the facility. It is OJJ's job to keep all staff and children across all its facilities safe. According to their written policy, OJJ does not require any of these measures.

3. Within the facilities, there should be twice daily temperature checks and general questions (cough, any other symptoms) for every child. If symptomatic at all, the facility should be in contact with the Department of Health and set up a medical assessment. If at all possible, every child that has come into contact with another child or staff member that tests COVID positive should be tested because we know that many people are asymptomatic carriers.[4] I would also test all staff who had been on the unit where the infected person was within the last 2-4 days. In Arkansas, for example, we had a child in a mental health hospital where a youth later tested positive (along with six others). Even though the child in our custody had been transferred out of the hospital 8 days earlier and was at a group home and had no symptoms, we managed to get him tested.

4. None of the four secure care facilities in Louisiana is designed to handle more than three or four children in the infirmary. The infirmaries are all bare minimum, open bay, with three or four beds and staff need to be inside to supervise. Swanson and ACY each have one negative pressure room but you can only put one patient there. There are only one or two nurses (a mix of RNs and LPNs) per shift at each facility. There is not enough PPE to manage an outbreak in any of the facilities based on the nature of COVID, even if they had were stockpiled according to the pandemic policy.

5. For any youth that are at risk because of underlying medical conditions – including hypertension, severe obesity, asthma[5] – in accordance with CDC guidelines I would increase medical surveillance (i.e. take their blood pressure every couple of hours) and make sure their medical management was in place in the instance they test positive for COVID. I would arrange necessary transport to the appropriate hospital for higher level care of treatment if it became necessary.

6. Per its pandemic policy, OJJ should have started with the assumption that the facilities will not be fully staffed and will lose approximately 30-40% of staff due to illness or illness in their family.[6] Because of high turnover and use of sick leave, OJJ's relief factor is almost 2:1, meaning for every guard assigned to a scheduled shift you need approximately two employees available to cover that shift. OJJ was already severely understaffed at all four

---

[4] CDC, "Clinical Presentation in Children," https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html (last visited May 7, 2020).
[5] CDC, "At Risk for Severe Illness," https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html (last visited May 7, 2020).
[6] Office of Juvenile Justice, Influenza Preparedness, Response and Recovery A.1.13, (December 11, 2019), available at https://ojj.la.gov/wp-content/uploads/2020/01/A.1.13.pdf.

facilities prior to the COVID outbreak.[7] Under normal circumstances, there are two staff per dorm. Staff take children to and from wherever they need to go, including to and from the infirmary and to and from the social worker.

7. It would be highly difficult to ensure social distancing within the dorms if they are used for quarantine or isolation. For example, in the dorms on the second floor of Bridge City Center for Youth, the beds are six feet apart. Therefore, for effective social distancing, you must ensure that the children stay on their beds at all times. The bathrooms are shared and would need to be individually sanitized between uses. It is impossible for staff to stay six feet away from the children and perform their jobs, putting both the staff and children at risk.

8. During this pandemic, we are able to maintain educational services in Arkansas because we use online schooling called Virtual Arkansas. This allows the children to continue to receive individualized educational services and allows those who are on-track to continue to progress timely towards getting their high school diploma or GED, while maintaining social distancing. OJJ should make every effort to keep schedules and programming as normal as possible amidst the pandemic and in compliance with CDC guidelines. Instead, OJJ shut down all their schooling and programming. Children have poor impulse control and get bored very easily. Levels of horseplay become higher and could turn into fights, especially if staff are also bored. You can breed lazy practices and high incidents of physical altercations between kids that is driven more by boredom than anything else. If possible, I would only isolate the dorms that need to be quarantined or isolated and let the other dorms run as normal – you want to maintain normalcy as much as possible with increased sanitation practices. If programming and school are not being provided, there is really no point of holding the children in the facilities.[8]

9. OJJ's first and continued response should have been to shrink the campuses as much as possible to protect children and staff. They should look at getting anyone within 30-45 days of release out early, look at doing furloughs (that are available for up to 30 days),[9] and identify anyone with an upcoming court review. If they had shrunk the size of the campuses, they could have lessened the likelihood of having COVID positive patients in those facilities

---

[7] Performance Audit Services, Oversight of Safety in Secure Care Facilities ("Safety Audit") (June 6, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/$FILE/000194C2.pdf ("Staffing challenges, such as high turnover, make it difficult for OJJ to maintain required staff to youth ratios, which affects the overall safety of the facilities.").

[8] Office of Juvenile Justice, "Secure Care Handbook for Parents," (Sept. 13, 2017), *available at* https://ojj.la.gov/wp-content/uploads/2017/09/SecureCareHandbookforParents_13September2017.pdf ("Youth in secure care receive a variety of treatment and rehabilitative services designed to help them learn to make better choices, provide life skills and prepare them for release. OJJ's goal is to help your son learn the life skills needed to become a law-abiding, productive citizen.").

[9] Office of Juvenile Justice, Furlough Process C.4.1, (July 11, 2017), *available at* https://ojj.la.gov/wp-content/uploads/2018/07/C.4.1.pdf

at all. Now that COVID is inside the facilities, shrinking the campuses minimizes the potential spread and the impact on operations. The Governor could instruct OJJ to effect widespread releases in a rational way. Any child who is furlough eligible should be furloughed after making sure the home they would go to does not pose a COVID risk to the child (which can be assessed virtually). If they test every child before they came back to the facility, no home evaluation is necessary. I would also prioritize furloughing any children that are at risk medically if they got COVID – including kids with a history of asthma or who are obese. There are adolescents who have died and their condition can turn very quickly. They need a higher level of medical care than can be provided at any of the facilities. Acadiana is in Bunkie and very far from any advanced life support facility – almost an hour. Swanson Center in Columbia is at least twenty or thirty minutes from a hospital. Shrinking the campus through early releases and furloughs ensures the health of any children and the staff that remain.

10. It is extremely important that family members and children in facilities have high levels of frequent contact right now, preferably visual contact. This manages the level of anxiety and fear on both ends.[10] Children should be allowed to have multiple phone calls a week and it should be switched over to a non-paid phone system. Case managers have direct lines that children can use to reach their family members as well. OJJ should make sure family members and children could have face-to-face video visitation as much as possible. Video conference capabilities already exists at all the facilities and at all the regional offices. OJJ can assist parents in setting up Zoom calls for any parents that have that capability. In Arkansas, we upped installation of TV monitors so that we could use Zoom for visitation and said children and parents can get as many phone calls as they want. I want parents to have connection to their child.

11. Information-sharing and transparency is key during a pandemic and should be built into OJJ's COVID response. Facility directors need to have the authority to answer direct questions from family members about their children and their medical status and what is happening at the facility, subject to any operational concerns. Facility directors should be accessible to parents. We have a responsibility and duty to be transparent with family members during this time and help them maintain their connection to their children.

12. OJJ's response to COVID-19 has put the children in their custody at risk of serious medical complications, including death. One of the most troubling responses is the level of force that is being used by officers – specifically probation officers – against children. For example, the

[10] Office of Juvenile Justice, "Secure Care Handbook for Parents," (Sept. 13, 2017), available at https://ojj.la.gov/wp-content/uploads/2017/09/SecureCareHandbookforParents_13September2017.pdf ("Support and visitation by family members are very important to your son's well-being. Your visits can motivate and inspire him to participate in programming and meet the goals of his treatment plan, which may result in an earlier release date. You can make a difference for your son. Your visits show that you care and that he has not been forgotten. While visiting, you will be able to meet with staff to discuss your son.").

use of pepper spray was immediately removed from the juvenile facilities and the future use of pepper spray prohibited back in 2003 and 2004 and has been prohibited ever since. It is not present in the OJJ disciplinary policy for facilities and there are no guidelines on its use.[11] Pepper spray is being used against children in response to horseplay and fights[12] – it is the first thing that the probation officers that are filling in for regular OJJ staff are using. The probation officers were authorized to carry pepper spray into the facilities by OJJ in an internal memo on March 17, 2020. They have never worked in a facility unless ordered to work in a facility. They have been given no training on how that role is different from supervising people in the community. The use of pepper spray under these circumstances could be lethal. It irritates the wet, mucus things in your body[13] – the wettest being the lungs. If a child who is pepper sprayed is COVID positive and hasn't been tested, you are inhibiting their ability to breath and could kill them. OJJ knows this has become a problem because in another internal memo dated April 27, the Interim Secretary said officers could no longer bring pepper spray into the facilities but that its use is still permitted if needed. Per the threat force continuum, probation officers can also use pressure points and handcuffs. OJJ has no lethal use of force policy for when they can pull their weapons or pepper spray and when it would be appropriate to discharge those weapons. Probation officers are trained to use a higher level of force than the usual OJJ staff. They are going into facilities with access to deadly weapons that they have no policy on how to use in those facilities. Instead of figuring out how to prevent an incident like the riot at Bridge City from happening again, the probation officers are using potentially harmful reactive measures inside the facilities that staff are usually prohibited from using.

13. OJJ uses Safe Crisis Management[14] and the first step is to recognize escalation of activities that could lead to a bad outcome, and then redirect the child in a non-tactical way and then guide with physical hand techniques that restrain movement. Restraint is only to be used when necessary to prevent the imminent threat of physical harm to the child (such as self-mutilation) or to others. You have to get approval verbally from shift supervisor before you move up to a higher level on the use of force continuum.[15] None of the facilities, besides Acadiana, are built for room confinement. The Cypress disciplinary wing at the Swanson Center for Youth at Monroe was shut down in 2005 and turned into a short-term crisis intervention unit. They are currently using it for suicide watch as well as reconstituted it as disciplinary lockdown unit. After the riot, OJJ moved children from Bridge City to Swanson

[11] Office of Juvenile Justice, Use of Interventions – Secure Care C.2.6, (August 13, 2018), available at https://ojj.la.gov/wp-content/uploads/2019/08/C.2.6.pdf
[12] "Riots, escapes and pepper spray: Virus hits juvenile centers," 4WWL, (May 3, 2020), available at https://www.wwltv.com/article/news/health/coronavirus/riots-escapes-and-pepper-spray-virus-hits-juvenile-centers/289-e52aa1ea-5680-47eb-a8c5-4c62af60cd4e
[13] National Capital Poison Center, "How Dangerous is Pepper Spray," https://www.poison.org/articles/how-dangerous-is-pepper-spray-201 (last visited May 7, 2020).
[14] Office of Juvenile Justice, Use of Interventions – Secure Care C.2.6, (August 13, 2018), available at https://ojj.la.gov/wp-content/uploads/2019/08/C.2.6.pdf
[15] Office of Juvenile Justice, Use of Interventions – Secure Care C.2.6, (August 13, 2018), available at https://ojj.la.gov/wp-content/uploads/2019/08/C.2.6.pdf

in a bus in order to lock them down without considering the transfer of infection between the two facilities and community spread, in accordance with CDC guidelines. The CDC guidelines say transport should only happen if necessary for medical isolation and quarantine, not for disciplinary purposes.[16] If I absolutely had to transfer children in the Arkansas facilities right now in order to ensure their safety and well-being, I would make sure that none of the children were COVID-positive before transferring.

14. I have reviewed internal OJJ guidance, including the "Emergency Plan COVID19" dated March 2020, the "Coronavirus Quarantine and Isolation Instructions" circulated on March 23, 2020, and the "Updated Isolation Instructions" circulated on March 31, 2020. None of them impact my opinion as to the insufficiency of OJJ's response and the risk that it poses to kids who are confined in the facilities. First of all, there is still no information that they have released or furloughed kids to shrink the campuses in an effort to keep both the children and staff.[17] That should have been their number one response and top priority. That was one of the first conversations we had in Arkansas. OJJ already knows who is furlough-eligible because it is discussed at every quarterly staffing meeting.[18] They also already know who is eligible for early release[19] and could have put into place a process to file motions to modify using specific criteria (such as SAVRY, offense, programming, etc.). In a matter of days, they could have had a prioritized list and started transferring kids home to keep both kids and staff safer.

15. None of their guidance adequately address sanitation, which is crucial to prevent against cross-contamination.[20] It is good that they have signs reminding kids to wash their hands, but there is nothing to ensure the living areas are clean. I have walked through each of these facilities and things have frequently appeared dirty and unsanitary. If staff wasn't doing a good job of maintaining them before and making sure the living areas sanitary, I assure you they aren't doing it now without proper guidance and oversight. For example, usually the kids shower two at a time (in separate stalls), that should be changed to one at a time and the bathrooms and all surfaces would need to be completely sanitized before the next group of kids comes in. Staff would either need to do the disinfecting or be directed to give the kids cleaning products and instruct them to wipe everything down thoroughly after they finish.

---

[16] CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

[17] With one exception – the Updated Isolation Instructions indicate that one single child was "on furlough for quarantine because of COVID symptoms."

[18] Office of Juvenile Justice, Youth Classification System and Treatment Procedures B.2.2, (April 8, 2019), available at https://ojj.la.gov/wp-content/uploads/2019/08/C.2.6.pdf

[19] Office of Juvenile Justice, Youth Classification System and Treatment Procedures B.2.2, (April 8, 2019), available at https://ojj.la.gov/wp-content/uploads/2019/08/C.2.6.pdf

[20] CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

16. The March 23, 2020 guidance confirmed that the "Quarantine Youth" are remaining in their dorms "at all times" with the exception of some limited outdoor recreation time. Rehabilitation requires meeting the needs of kids identified in their individual assessments to the best of your ability. It includes mental health care, group therapy, individual therapy, tailored education, and interventional programs such as "Thinking for a Change," "Healthy Masculinity," and "Anger Management-Cage Your Rage."[21] OJJ uses an overall behavioral management program called LAMOD, tailored to youth in Louisiana, where kids work their way up through phases of: (1) Orientation; (2) Emerging—Self Awareness; (3) Adaptation—Applying Skills; and (4) Transformation—Role Model and Leadership. The program depends on youth and staff small-group interaction, with family and peer involvement.[22] If kids aren't able to move up the stages, they aren't getting the rehabilitation that they need as per OJJ's own theory of change. OJJ is not providing educational services and programming at a level that is sufficient to provide the children with any rehabilitation, and I wouldn't be surprised if some of the kids started to backslide in the progress that they had made as a result.[23] Initially, OJJ continued running in-person school, but that was shut down by at least March 23, 2020, when everyone went into dorm lockdown. Nothing suggests that they are using remote education, like we are in Arkansas. They are not trying to provide any teletherapy or remote group programming. OJJ is required to provide education and rehabilitative services. The agency's top priority to the children should have been to maintain as much normalcy, education, and programming as safely as possible under the circumstances.

17. Based on my extensive first-hand knowledge of the four secure care facilities, the Updated Isolation Instructions circulated on March 31, 2020, do not provide for the safety and well-being of children that are being held in those facilities. First of all, the instructions do not even reference or provide guidance for use of the Cypress disciplinary wing at Swanson Monroe, which we know is being used for disciplinary lockdown as well as medical isolation for kids who tested positive for COVID-19. The instructions contemplate using three of the four Holly units and have up to 12 children per unit – those who tested negative in A, those who are awaiting test results in C, and those who are positive in D. To date, there is only 1 out of the 29 kids who were tested that tested negative – so it is more accurate that they are holding kids who have not been tested but that they are presuming to be negative in A. The Holly units have separate entrances and exits, but their ventilation systems are shared. The units themselves are just open bays and would not allow for 12 children to have adequate social distance during any recreation. The plan also contemplates using the Mimosa unit,

[21] Office of Juvenile Justice, "Treatment Services," https://ojj.la.gov/serving-youth-families/youth-in-secure-care-facilities/treatment-services/ (last visited May 24, 2020).
[22] Office of Juvenile Justice, LAMOD Staff Manual, 4th ed. (2017), available at https://ojj.la.gov/wp-content/uploads/2017/09/A.2.7-1.pdf ("LAMOD is the catalyst that drives the therapeutic process in Louisiana's secure care facilities. LAMOD is a youth-centered treatment philosophy upon which the culture is in OJJ secure care facilities is built, and in which staff provides a learning environment for the youth to grow and develop.").
[23] Office of Juvenile Justice, "Educational Services," https://ojj.la.gov/serving-youth-families/youth-in-secure-care-facilities/educational-services/ (last visited May 24, 2020).

which was previously shut down and all the beds were removed. The instructions say that Mimosa is a "fully functional dorm," but as of July or August of 2019, that unit was not at all functional, did not have a fence, and needed work on the HVAC system. The only way to put 24 cots in Mimosa that are six feet apart would be to have beds upstairs and downstairs, which would leave no room for recreation.

18. Acadiana Center for Youth has 6 dorms but is only operating 3 of them. If you spread the kids across the additional dorms (which would allow them to better practice social-distancing), you would need additional staff. The instructions do not contemplate using those empty dorms as-needed for medical isolation or quarantine and instead have kids awaiting test results in the infirmary. That means that any kids who get hurt or need medical attention can't go to the infirmary without the risk of COVID-19 exposure.

19. Bridge City Center for Youth has designated the "BI" (Behavioral Intervention Rooms) for children who "tested negative for COVID/7 days if symptom free." First of all, there is no justification for why kids who have tested negative need to be isolated from other children who are presumed negative. Furthermore, there is no reason that they should be putting any children in the BI cells for medical isolation purposes. Those cells are punitive and problematic for children's mental well-being (especially if used for prolonged periods of time) and are only intended to be used for very short periods of time for children whose behavior is out of control and they pose an imminent harm to others. OJJ policy requires they be removed from these cells as soon as their behavior no longer poses a threat to others.[24] The notes indicate that maybe these are being used as a type of "step-down" unit for kids who previously tested positive for COVID-19 and are now testing negative or not showing symptoms. The BI cells should not be part of any medical isolation plan, particularly for kids who are recovering from COVID-19, and children who are testing negative (on the assumption that they will even be doing testing) should be returned to their dorm. The chapel has been designated for up to 40 kids who would need to be quarantined if they leave the facility and come back but it does not have the capacity for 40 kids to practice social distancing and also have recreation space. There are no showers or toilets in the chapel itself.

20. I have reviewed on several occasions the two reports issued by the Louisiana Legislative Auditor after their most recent audit of the OJJ secure care facilities – the Oversight of Rehabilitation and Treatment in Secure Care Report[25] and the Oversight of Safety in Secure

[24] Office of Juvenile Justice, Behavior Intervention Rooms B.2.21 (May 31, 2019), https://ojj.la.gov/wp-content/uploads/2019/06/B.2.21.pdf ("Staff shall never use a BI room for discipline, punishment, administrative convenience, retaliation, staffing shortages, or reasons other than a temporary response to behavior that threatens immediate harm to the youth or others.").
[25] Performance Audit Services, Oversight of Rehabilitation and Treatment in Secure Care Facilities ("Rehabilitation Audit"), (June 13, 2018), https://lla.la.gov/PublicReports.nsf/71C88F049AA3563A862582AB0075C861/$FILE/00019598.pdf

Care Facilities Report.[26] There are multiple findings in those audits that exacerbate the risk to the safety and well-being of children in secure care due to OJJ's COVID-19 response. OJJ staff, which included myself at the time, were provided with the Legislative Auditor's findings and recommendations and were asked to respond. I have addressed just a few examples of those findings.

21. First, OJJ consistently has issues with staffing practices such as staff-to-youth ratios and turnover rates, which directly impact staff ability to monitor youth, maintain safety, and provide quality interactions. The Legislative Auditor found that Bridge City had a turnover rate of 62.3% and Swanson Monroe and Swanson Columbia had a turnover rate of 30.6%.[27] High rates of staff turnover can destabilize a facility, contributing to misbehavior and violence. Bridge City has seen frequent turnover in Juvenile Justice Specialist Positions, as well as facility director and other management positions.[28] Because of difficulties with recruitment and retention, the Secure Care facilities are not always compliant with the staffing ratios required by the federal Prison Rape Elimination Act (1:8 staff to youth during waking hours and 1:16 staff to youth during sleeping hours).[29] The high turnover rates and inadequate staff-to-youth ratios have been exacerbated during COVID-19, particularly since at least 41 staff members have tested positive for COVID-19.[30] Rather than fill in these staffing shortages with probation and parole officers who are not trained to work with youth in secure care facilities, OJJ should have identified and moved to release and furlough as many youth as possible so that less staff are needed in the facilities to maintain adequate staff-to-youth ratios.

22. Second, OJJ has been on notice of the need to reduce the use of room confinement, solitary confinement, isolation, and seclusion, which is currently being employed across all four of the facilities in their COVID-19 quarantine and isolation instructions. Room confinement is defined as any time a youth is physically or socially isolated from other youth.[31] Nationally, juvenile justice agencies have been moving away from using room confinement, and 10 states have banned punitive solitary confinement. Research has shown that putting youth in confinement has negative public safety consequences, does not reduce violence, and may actually increase recidivism. It has also shown that facilities that use minimal room confinement are safer and have healthier staff to youth relationships, which lead to reduced recidivism rates.[32] Swanson-Monroe has restarted housing children in the individual cells in the previously-closed Cypress unit for both disciplinary and medical purposes. Bridge City is bafflingly using its Behavior Intervention rooms to confine children who have tested

---

[26] Performance Audit Services, Oversight of Safety in Secure Care Facilities ("Safety Audit"), (June 6, 2018), https://www.lla.la.gov/PublicReports.nsf/64DF5EBB49AE4404862582A40078718D/$FILE/000194C2.pdf

[27] Safety Audit at 4-7.

[28] Safety Audit at 4-5.

[29] Safety Audit at 6.

[30] Office of Juvenile Justice, OJJ COVID-19 Information, https://ojj.la.gov/ojj-covid-19-information/ (last visited May 25, 2020).

[31] Safety Audit at 14.

[32] Safety Audit at 14.

negative. The Legislative Auditor found that OJJ does not collect room confinement information in a way that is easily aggregated and analyzed, and that the room confinement paperwork is not always been completed accurately and honestly[33] which is particularly problematic in light of their quarantine and isolation instructions to use those rooms for purposes other than temporary behavioral intervention.

23. OJJ's COVID-19 response includes 23-hour a day dorm isolation and suspension of educational and rehabilitative services and programming. This is problematic for the rehabilitation of all children, and specifically so for the approximately 44% of children that OJJ has estimated have serious mental illnesses.[34] Even before the suspension of services, the Legislative Auditor found that at least 65% of children in the facilities were housed in general population dorms and were not being provided with individualized, evidence-based services.[35] "Programs and services are considered evidence based when they have demonstrated effectiveness through scientific research and evaluation. Both research and field experience show that implementing evidence-based programs and services with fidelity correlates to reduced recidivism and improved outcomes for youth. National best practices recommend that juvenile justice agencies fund services shown to reduce recidivism. Best practices also state that youth should participate in life skills programs that use an established curriculum and that staff implement the curriculum consistently.[36] The Legislative Auditor found that the group therapy sessions that were provided to the kids before COVID-19 did not have a standard structure, that there was no requirement that the services be evidence-based, that some staff were not prepared and chose the topic once the group started, and that some topics seemed unrelated to treatment.[37] Furthermore, OJJ does not consistently document group therapy sessions for all dorms, preventing OJJ from monitoring what services the kids are receiving and how consistently they are receiving them.[38] Even before COVID-19, data showed that on average the kids were only being provided with a group therapy session on 44% of the days they were in secure care.[39] OJJ also does not collect adequate documentation on the therapy sessions.[40] This lack of evidence-based services and standardized group therapy, as well as the lack of documentation, is particularly problematic in light of COVID-19 when these unstructured group therapy sessions are hypothetically the ONLY method of rehabilitation that OJJ may claim they are still offering ad-hoc.

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

Signature:

[33] Safety Audit at 15.
[34] Rehabilitation Audit at 9.
[35] Rehabilitation Audit at 11.
[36] Rehabilitation Audit at 12.
[37] Rehabilitation Audit at 12.
[38] Rehabilitation Audit at 13.
[39] Rehabilitation Audit at 13.
[40] Rehabilitation Audit at 13.

/s/ Glenn Holt

May 26., 2020

DECLARATION OF DR. CARLOS FRANCO-PAREDES

I, Dr. Carlos Franco-Paredes, state and declare as follows:

I. Background and Specializations

1. My name is Carlos Franco-Paredes. I am an Associate Professor of Medicine at the University of Colorado in the Department of Medicine, Division of Infectious Diseases. I completed my internal medicine residency and infectious diseases fellowship at Emory University School of Medicine. I also hold a public health degree in global health from the Rollins School of Public Health at Emory University with a concentration on the dynamics of infectious disease epidemics and pandemics. I also have more than twenty years of relevant clinical experience. I participated in developing international guidelines for pandemic influenza preparedness and response as well as the World Health Organization global health action plan for developing seasonal and pandemic influenza vaccine.

2. As an infectious diseases clinician, I have experience providing care to individuals in civil detention centers in the United States (US) and have performed medical forensic examinations and medical second opinion evaluations for patients in the custody of the Department of Homeland Security, Immigration and Customs Enforcement (ICE). I have also provided direct care for many patients in ICE custody or incarcerated settings living with HIV-infection at my current academic institution.

3. I also have experience treating COVID-19 patients in the medical units and intensive care units at Anschutz Medical Center in Aurora, Colorado where I have provided direct-patient care to more than 70 individuals with this infection.

4. Since the beginning of the COVID-19 pandemic, I have collaborated with civil rights attorneys and as an independent court-appointed inspector in carceral settings with ongoing outbreaks of COVID-19. I have served as a medical expert in six cases related to COVID-19 in incarceration settings, including West Metro Detention Center in the Miami-Dade County, Florida and the Los Angeles County Jail System (four jails). I have also served as medical expert and conducted jail inspections during the ongoing pandemic at Weld-County Jail in Colorado (April 10 and April 24), Oakland County Jail in Michigan (April 23), and Prince George's County Jail in Maryland (May 6 and May 7). The Federal Judge Paula Xinis, of the US District of Maryland, ordered my inspection of Prince George's County Jail and appointed me to perform a site inspection as a medical expert (Keith Seth et al vs. Mary Lou McDonough, Director of the Prince George's County Department of Corrections, Prince George's County, Maryland).

5. I have written and published many relevant scientific publications on the topics of infectious diseases, pandemics, and epidemics, particularly in influenza. I have 204 scientific publications in peer-reviewed scientific journals. My last six publications have focused on the COVID-19 topic including an upcoming publication in the New England Journal of Medicine where my co-author and I address the need for further COVID-19 testing to guide population management in jails and prisons in the U.S. I teach a class at the school of medicine on caring for underserved populations, including immigrants and incarcerated populations and in best practices in global health. I have written a textbook on infectious diseases.

6. I present my Curriculum Vitae attached as Exhibit A.

II. Documents Reviewed in Preparation of this Declaration

7. In addition to references in footnotes, in the preparation for this declaration, I reviewed the following scientific references, relevant medical documents, and public health websites:

a. Johns Hopkins University. Coronavirus Resource Center Available at: https://coronavirus.jhu.edu/map.html. Accessed: May 26, 2020.
b. Kinner SA, Young JT. Understanding and improving the health of people who experience incarceration: An overview and synthesis. Epidemiol Rev 2018; 40: 4-11
c. CDC-Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) Available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html). Accessed: April 12, 2020.
d. Johns Hopkins University. Coronavirus Resource Center Available at: https://coronavirus.jhu.edu/map.html. Accessed: April 12, 2020.
e. The New York Times. Coronavirus in the U.S.: Latest map and case count – The New York Times. Available at: https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?referringSource=articleShare. Accessed: May 26, 2020.
f. Fauci AS. Infectious diseases: considerations for the 21st century. Clin Infect Dis 2001; 32: 675-85.
g. Finnie TJR, Copley VR, Hall IM, Leach S. An analysis of influenza outbreaks in institutions and enclosed societies. Epidemiol Infect 2014; 14: 107-113.
h. Chao W-C, Liu P-Y, Wu C-L. Control of an H1N1 outbreak in a correctional facility in central Taiwan. J Microbiol Immunol Infect 2017; 50: 175-182.
i. Dolan K, Wirtz AL, Moazen B, Ndeffo-Mbah M, Galvani A, Kinner SA, Courtney R, McKee M, Amon JJ, Maher L, Hellard M, Beyrer C, Altice FL. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. Lancet 2016; 388 (10049): 1089-1102.
j. Prisons and custodial settings are part of a comprehensive response to COVID-19. Lancet Public Health 2020; 5(4): e188-e189.
k. CDC. Interim guidance on management of coronavirus disease 2019 (COVID-19) in correctional and detention facilities. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html. Accessed: April 12, 2020.
l. Van Doremalen N, Bushmaker T, Morris DH, and Holbrook MG, Gamble A, Williamson BN, Tamin A, Harcourt JL, Thornburg NJ, Gerber SI, Lloyd-Smith JO, de Wit E, Munster VJ. Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. N Engl J Med 2020; Mar 17. doi: 10.1056/NEJMc2004973.
m. Mizumoto K, Chowell G. Transmission potential of the novel coronavirus (COVID-19) onboard the diamond Princess Cruises Ship, 2020. Infect Dis Modelling 2020; 5: 264-270.
n. Sanche S, Lin YT, Xu C, Romero-Severson E, Hengartner N, Ke R. High contagiousness and rapid spread of severe acute respiratory syndrome coronavirus 2. Emerg Infect Dis. 2020 Jul https://doi.org/10.3201/eid2607.200282.
o. Swerdlow DL, Finelli L. Preparation for possible sustained transmission of 2019 Novel Coronavirus. Lessons from previous pandemics. JAMA 2020; 323(12): 1129-30.
p. Patrozou E, Mermel LA. Does influenza transmission occur from asymptomatic infection or prior to symptom onset? Public Health Rep 2009; 124: 193-96.

q. Thompson R. Pandemic potential of 2019-nCoV.Lancet Infect Dis 2020; 20 March 20; doi.org/10.1016/S1473-3099 (20)30068-2.
r. Li R, Pei S, Chen B, Song , Zhang T, Shaman J. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). Science 10.1126/scienceabb3221 (2020).
s. Federal Bureau of Prisons. Available at: https://www.bop.gov/coronavirus/. Accessed: May 26, 2020.
t. The Guardian. Data form US south shows African Americans hit hardest by COVID-19. https://www.theguardian.com/world/2020/apr/08/black-americans-coronavirus-us-south-data. Accessed: April 27, 2020.
u. MMWR. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020; March 27, 2020: 69(12): 339-342.

8. I have also reviewed the following documents related to the instant litigation:

a. OJJ's Influenza Preparedness, Response, and Recovery Youth Services Policy;
b. OJJ's Emergency Plan for COVID-19, March 18;
c. OJJ's Updated COVID-19 Guidance, March 23; and
d. OJJ's Updated Isolation Instructions, March 31.

III. Analysis and Expert Opinion

A. COVID-19

9. The catastrophic consequences of the current COVID-19 pandemic in terms of human and social disruption costs can be distilled into two major factors: (a) the transmissibility of this infection and (b) the severity of the disease in human populations.

10. The Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is a newly emerging zoonotic agent initially identified in December 2019 that as of the date of this writing, has spread to 188 countries, causing 5,594,175 confirmed cases and 350,547 deaths worldwide. This viral pathogen causes the Coronavirus Disease 2019 (COVID-19). Infection with COVID-19 is associated with significant morbidity and mortality, especially in patients above 50 years of age and those with chronic medical conditions. As of May 26, 2020, there have been 1,681,418 confirmed cases of COVID-19 with 98,929 deaths reported in the United States. There have been COVID-19 deaths in every U.S. state.

11. Since late March and early April and up until now, correctional facilities in the US have become the epicenters of COVID-19 transmission. There are an increasing number of outbreaks identified on a daily basis with more than 30,000 confirmed cases and more than 450 deaths among inmates and approximately 50 deaths among staff members.[1] As recent evidence indicates from custodial settings in other States such as Ohio, and from Sterling prison in Colorado, even a small outbreak of confirmed COVID-19 cases reflects just the tip of the iceberg of a larger outbreak with a larger number of undetected cases in those with no

[1] UCLA Law COVID-19 behind bars data project by Professor Sharon Dolovich, Director – Available at: https://docs.google.com/spreadsheets/d/1X6uJkXXS-O6eePLxw2e4JeRtM41uPZ2eRcOA_HkPVTk/edit#gid=1197647409

symptoms or mild symptoms. The number of people who are asymptomatic or exhibiting mild symptoms may represent up to 80% of those with coronavirus infection that are responsible for transmitting more than 44% of the cases.

12. COVID-19 can result in respiratory failure, multiorgan dysfunction, and death. It can also severely damage lung tissue, affect cardiac functions, and cause neurological damage, loss of respiratory capacity, and multiorgan dysfunction. These complications can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.[2]

13. Infected individuals who do not die from the disease may face health consequences that can negatively affect their quality of life. Further, COVID-19 may involve a prolonged recovery period due to deconditioning requiring extensive rehabilitation and consuming significant healthcare resources. Furthermore, some individuals develop important complications following an episode of COVID-19 infection including deep venous thrombosis or other coagulopathies including bleeding disorders, COVID-19 induced asthma, Guillian-Barre syndrome, and other long-term permanent sequelae.[3]

14. Although the CDC provided guidance for who is deemed "high risk" in the general population, that definition is broader within a detained setting and includes the following:
    a. People age 50 or older;
    b. People with a history of smoking;
    c. Anyone diagnosed with cancer, autoimmune disease (including lupus, rheumatoid arthritis, psoriasis, Sjogren's, Crohn's), chronic lung disease (including asthma, COPD, bronchiectasis, idiopathic pulmonary fibrosis), history of cardiovascular disease (MI), chronic arthritis (rheumatoid, psoriatic), chronic liver or kidney disease, diabetes, hypertension, heart failure, blood disorders, inherited metabolic disorders, HIV/AIDS, or those who take steroids to treat chronic conditions. Obesity is also an increasingly recognized risk factor for developing complicated clinical courses.

15. COVID-19 can be fatal for persons of any age, and even some younger and healthier individuals who contract COVID-19 may require supportive care or die. This includes younger individuals residing in jails, prisons, and juvenile detention facilities. For example, the number of cases of severe myocarditis have been identified in otherwise healthy young individuals, including children.[4]

16. For example, in the Sterling Correctional Facility, where the Department of Corrections performed prevalence testing after only a few confirmed cases of COVID-19 among

---

[2] CDC-Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) Available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html). Accessed: May 16, 2020.

[3] Extance A. COVID-19 and long term conditions: what if you have cancer, diabetes, or chronic kidney disease? Brit Med J 2020; 368:m1174; Pennington E. Asthma increases the severity of COVID-19. Cleveland Clin J Med May 12, 2020; doi:10.3949/ccjm.87a.ccc002.; Handu D, Moloney L, Rozga M, Cheng F. Malnutrition Care during the COVID-19 Pandemic: Considerations for Registered Dietitian Nutritionists Evidence Analysis Center. J Acad Nutr Diet. 2020 May 14. doi: 10.1016/j.jand.2020.05.012; Connors J, Levy J. COVID-19 and its implications for thrombosis and anticoagulation. Blood 2020

[4] She J, Liu L, Liu W. COVID-19 epidemic: Disease characteristics in children *J Med Virol.* 2020;10.1002/jmv.25807.

symptomatic inmates, they identified another 538 infected inmates who were asymptomatic. For this pandemic, the use of temperature screens and assessment of symptoms is insufficient when instituted in correctional facilities; and furthermore, it may actually foster further transmission by providing a false sense of security.

17. In summary, this unprecedented pandemic calls for unprecedented measures in every setting but particularly in congregate settings. No one living inside the OJJ facilities or outside in the larger community is safe until there is interruption of coronavirus transmission.

B. OJJ's Policies

18. I have reviewed OJJ's COVID-19 policies in response, and it is my expert medical opinion that they are deficient in numerous ways.

19. Among 220 kids residing in OJJ secure care facilities, only 29 were tested for infection. Of the 29 tested, 28 of them had positive COVID-19 tests. This high attack rate indicates that the extent of the outbreaks is much larger than what is reported because presymptomatic and asymptomatic cases are between 50 to 80% of those infected. It is safe to assume that 28 infections may represent only 20% of those actually infected and transmitting the infection.[5] Consistently, when the number of staff members with confirmed COVID-19 infection is higher than the number of detainees with positive COVID-19 tests, it indicates that there is a large number of undetected infections inside these centers. In addition, because of their undetected infection status, they continue to spread the infection to others silently.

20. Without further viral testing such as universal testing approaches, it is difficult to identify the true impact of the outbreak in the OJJ facilities in Louisiana. However, I would note that when viral tests are conducted among all or most of detainees, these outbreaks are in fact much more extensive. In fact, every correctional facility that I have inspected along with many published experiences of outbreaks among other jails and prisons nationwide confirm this fact. We are only seeing the tip of a larger iceberg given the high rate of asymptomatic infections or those tested at the time they were presymptomatic. In correctional facilities with only a few confirmed cases, when viral testing is performed among contacts and asymptomatic individuals, a large number of undetected infections are consistently identified. Insufficient viral testing leads to blind and inefficient action guiding population management inside correctional facilities.

21. Additionally, without testing for infection those exposed and in quarantine may continue to transmit the infection if transferred to a different unit. There is ample evidence that transferring detainees even after the completion of a quarantine period without viral testing, may spread the infection to other pods or units within the correctional facility. Similarly, transferring them to another facility may pose a major risk of spreading the outbreak to the second facility.

[5] Gandhi M, Yokoe DS, Havlir DV. Asymptomatic transmission, the Achilles' Heel of current strategies to control Covid-19. N Engl J Med 2020. April 24. DOI: 10.1056/NEJMe2009758.
Arons MM, Hatfield KM, Reddy SC, et al. Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. N Engl J Med 2020. DOI: 10.1056/NEJMoa2008457.

22. Non-pharmaceutical interventions such as social distancing are crucial public health interventions to ameliorate the impact of this pandemic, and complying with social distance in correctional facilities is a major challenge. Incomplete implementation of social distancing as it occurs in these secure care facilities is insufficient to reduce COVID-19 transmission. Additionally, temperature checks and symptom screening are also insufficient to interrupt COVID-19 transmission within any correctional facility including these secure care facilities. Evidence of mass outbreaks from other correctional facilities validates that even when excellent infection control practices are in place including wearing a face mask, if they are coupled with incomplete or inconsistent adherence to social distancing, these practices will be insufficient to contain the occurrence of new cases. Especially in settings such as juvenile detention centers, where there is ongoing sustained transmission of COVID-19 within the broader Louisiana community. Social distancing requires maintaining a distance of at least six feet from each other at all times.

23. Finally, pepper spray (oleoresin capsicum), also referred as tear gas, riot control agent, harassing agent, incapacitating agent and lacrimator gas may pose significant toxicity, particularly during this pandemic and in the setting of an existing and proven outbreak of coronavirus among juveniles residing inside OJJ centers.[6] Following exposure even to minimal concentrations, pepper spray causes immediate and intense eye, nose, mouth, skin, and respiratory tract irritation that can lead to temporary incapacitation of exposed juveniles. It is my expert opinion that the use of pepper spray as a means of controlling young individuals would predispose them to nasopharyngeal mucosa irritation that could facilitate novel coronavirus infection and potentially a higher viral inoculum entering through mucosa of the respiratory tract, which may lead to more severe clinical manifestations of COVID-19.

24. The current outbreak among juveniles residing at the OJJ centers demonstrates that currently implemented interventions are largely insufficient to reduce the outbreak. Severe COVID-19 and death has been described among children in many settings, albeit less frequently than in adults; we should not assume that severe COVID-19 and death is exclusive to adult populations. Severe myocarditis, Adult Respiratory Distress Syndrome (ARDS), inflammatory-multiorgan dysfunction, and other severe manifestations of COVID-19 infection also occur in children.

25. **Therefore, it is my expert opinion that now that there are no ongoing educational or rehabilitative activities conducted in these facilities, allowing these young individuals**

---

[6] Pepper spray inhalation-induced acute polyneuropathy mimicking Guillain-Barre syndrome.
Özçora GDK, Çıraklı S, Canpolat M, Doğanay S, Kumandaş S.Turk Pediatri Ars. 2019 Mar 1;54(1):53-56. doi: 10.14744/TurkPediatriArs.2019.52533. eCollection 2019.PMID: 31217711
Yeung MF, Tang WY.Clinicopathological effects of pepper (oleoresin capsicum) spray.
Hong Kong Med J. 2015 Dec;21(6):542-52. doi: 10.12809/hkmj154691. Epub 2015 Nov 6.PMID: 26554271.
Pershing LK, Reilly CA, Corlett JL, Crouch DJ. Assessment of pepper spray product potency in Asian and Caucasian forearm skin using transepidermal water loss, skin temperature and reflectance colorimetry. J Appl Toxicol. 2006 Jan-Feb;26(1):88-97. doi: 10.1002/jat.1113.PMID: 16220469
Schep LJ, Slaughter RJ, McBride DI.Riot control agents: the tear gases CN, CS and OC-a medical review. J R Army Med Corps. 2015 Jun;161(2):94-9. doi: 10.1136/jramc-2013-000165. Epub 2013 Dec 30.PMID: 24379300.
Busker RW, van Helden HP. Toxicologic evaluation of pepper spray as a possible weapon for the Dutch police force: risk assessment and efficacy. Am J Forensic Med Pathol. 1998 Dec;19(4):309-16. doi: 10.1097/00000433-199812000-00003.PMID: 9885922 Review.

to reside with their parents or guardians would provide them with a safer living environment during this severe pandemic. Residing outside OJJ facilities would allow them to practice critical social distancing, wash their hands frequently, and take other preventive measures that would not only protect them but that would ultimately assist in curbing the epidemic in the State of Louisiana. At least, it is my professional recommendation that releasing those with medical conditions that put them at risk of complications and those with upcoming release dates should be a public health priority. Given the severity of this pandemic, interrupting transmission in correctional facilities and juvenile detention centers is a crucial public health intervention. As we have come to learn, no one inside correctional facilities or in the larger community, is safe until everyone is safe.

26. I am ready and willing to do a site inspection of any or all of the four OJJ secure care facilities and provide my findings and recommendations to OJJ and the Court, as needed.

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

Executed this 26th day of May, 2020.

Carlos Franco-Paredes MD, MPH, DTMH
Associate Professor of Medicine
Division of Infectious Diseases
University of Colorado, Anschutz Medical Center
Infectious Diseases Fellowship Training Program

Carlos Franco-Paredes, MD, MPH

Revised: 05/21/2020

PERSONAL INFORMATION

Carlos Franco-Paredes, M.D., M.P.H.
Carlos.franco-paredes@cuanschutz.edu
carlos.franco.paredes@gmail.com
U.S. Citizen and Mexican Citizen
Languages: English and Spanish
ORCID: 0000-0001-8757-643X

CURRENT PROFESSIONAL POSITION AND ACTIVITIES:

- Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus and Infectious Diseases (July 2018 - ongoing).
- Fellowship Program Director, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus (March 2019- ongoing).

EDUCATION

1989 -1995	M.D. - La Salle University School of Medicine, Mexico City, Mexico
1996-1999	Internship and Residency in Internal Medicine, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellowship in Infectious Diseases, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellow in AIDS International Training and Research Program, NIH Fogarty Institute, Rollins School of Public Health, Emory University, Atlanta, GA
1999 - 2002	Masters Degree in Public Health (M.P.H.) Rollins School of Public Health, Emory University, Atlanta, GA, Global Health Track
2001-2002	Chief Medical Resident, Grady Memorial Hospital, Emory University School of Medicine, Atlanta, GA
2006	Diploma Course in Tropical Medicine, Gorgas. University of Alabama, Birmingham and Universidad Cayetano Heredia, Lima Peru

CERTIFICATIONS

1999-Present	Diplomat in Internal Medicine American Board of Internal Medicine (Recertification 11/2010-11/2020)
2001-present	Diplomat in Infectious Diseases, American Board of Internal Medicine, Infectious Diseases Subspecialty (Recertification 04/2011-04/2021)
2005-present	Travel Medicine Certification by the International Society of Travel Medicine
2007-present	Tropical Medicine Certification by the American Society of Tropical Medicine – Diploma in Tropical Medicine and Hygiene (DTMH - Gorgas)

EMPLOYMENT HISTORY:

- 2002 - 2004 - Advisor to the Director of the National Center for Child and Adolescent Health and of the National Immunization Council (NIP), Ministry of Health

Mexico; my activities included critical review of current national health plans on vaccination, infectious diseases, soil-transmitted helminthic control programs; meningococcal disease outbreaks in the jail system, an outbreak of imported measles in 2003-2004 and bioterrorism and influenza pandemic preparedness. I represented the NIP at meetings of the Global Health Security Action Group preparation of National preparedness and response plans for Mexico

- 2005 – 2011- Co-Director Travel Well Clinic, Emory University
  Emory Midtown Hospital
- 2004- 8/2009 -Assistant Professor of Medicine
  Department of Medicine, Division of Infectious Diseases
  Emory University School of Medicine, Atlanta GA
- 3/2008-10/2009 Consultant WHO, HQ, Geneva, Influenza Vaccine
- 9/2009- 3/2011 Associate Professor of Medicine
  Department of Medicine, Division of Infectious Diseases
  Emory University School of Medicine, Atlanta GA
- 1/2007 – 3/2011 Assistant Professor of Public Health
  Hubert Department of Global Health
  Rollins School of Public Health, Emory University, Atlanta GA
- 4/2011 –5/2013 - Associate Professor of Public Health in Global Health
  Hubert Department of Global Health
  Rollins School of Public Health, Emory University, Atlanta GA
- 2010 - WHO HQ Consultant for a 4-month-period on the Deployment of H1N1 influenza vaccine in the African Region, Jan to March 2010, Switzerland Geneva, WHO HQ 2010 sponsored by John Snow Inc. USAID, Washington, D.C.
- 2014-2015 - Consultant International Association of Immunization Managers, Regional Meeting of the Middle Eastern and North African Countries and Sub Saharan Africa, held in Durban South Africa, Sept 2014; and as rapporteur of the Inaugural Conference, 3-4 March 2015, Istanbul, Turkey.
- 3/2011- 5/2017 - Phoebe Physician Group –Infectious Diseases Clinician Phoebe Putney Memorial Hospital, Albany, GA.
- 5/2015 - 9/2015 - Consultant Surveillance of Enteric Fever in Asia (Pakistan, Indonesia, Bangladesh, Nepal, India) March 2015-October 2015.
- June 19, 2017-June 31, 2018–Visiting Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver, Anschutz Medical Campus
- June 2004- present - Adjunct Professor of Pediatrics, Division of Clinical Research, Hospital Infantil de México, Federico Gómez, México City, México. Investigador Nacional Nivel II, Sistema Nacional de Investigadores (12/2019); SNI III Sistema Nacional de Investigadores (1/2020-); Investigador Clínico Nivel E, Sistema Nacional de Hospitales

HONORS AND AWARDS

1995 Top Graduating Student, La Salle School of Medicine
1997 Award for Academic Excellence in Internal Medicine, EUSM
1999 Alpha Omega Alpha (AOA) House staff Officer, EUSM
2002 Pillar of Excellence Award. Fulton County Department of Health and Wellness Communicable Disease Prevention Branch, Atlanta GA
2002 Emory University Humanitarian Award for extraordinary service in Leadership Betterment of the Human Condition the Emory University Rollins School of Public Health
2002 Winner of the Essay Contest on the Health of Developing Countries: Causes and Effects in Relation to Economics or Law, sponsored by the Center for International Development at Harvard University and the World Health Organization Commission on Macroeconomics Health with the essay "*Infectious Diseases, Non-zero Sum Thinking and the Developing World"*
2002 *"James W. Alley"* Award for Outstanding Service to Disadvantaged Populations, Rollins School of Public Health of Emory University May 2002. Received during Commencement Ceremony Graduation to obtain the Degree of Masters in Public Health
2006 Golden Apple Award for Excellence in Teaching, Emory University, School of Med
2006 Best Conference Award Conference, "*Juha Kokko*" Best Conference Department of Medicine, EUSM
2007 "*Jack Shulman*" Award Infectious Disease fellowship, Excellence in Teaching Award, Division of Infectious Diseases, EUSM
2007 Emerging Threats in Public Health: Pandemic Influenza CD-ROM, APHA's Public Health Education and Health Promotion Section, Annual Public Health Materials Contest award
2009 National Center for Preparedness, Detection, and Control of Infectious Diseases. Honor Award Certificate for an exemplary partnership in clinical and epidemiologic monitoring of illness related to international travel. NCPDCID Recognition Awards Ceremony, April 2009. CDC, Atlanta, GA
2012 The ISTM Awards Committee, directed by Prof. Herbert DuPont, selected the article "Rethinking typhoid fever vaccines" in the Journal of Travel Medicine (Best Review Article)
2012 Best Clinical Teacher. Albany Family Medicine Residency Program
2018 Outstanding Educator Award – Infectious Diseases Fellowship, Division of Infectious Diseases, University of Colorado, Anschutz Medical Center, Aurora Colorado

EDITORSHIP AND EDITORIAL BOARDS

2007-Present Deputy/Associate Editor PLoS Neglected Tropical Disease Public Library of Science
2017-2018 Deputy Editor, Annals of Clinical Microbiology and Antimicrobials BMC
2007-2019 Core Faculty International AIDS Society-USA -Travel and Tropical Medicine/HIV/AIDS

Carlos Franco-Paredes, MD, MPH

INTERNATIONAL COMMITTEES

2018- Member of the Examination Committee of the International Society of Travel Medicine. Developing Examination Questions and Proctoring the Certificate in Traveler's Health Examination
Proctor Certificate of Traveler's Health Examination (CTH) as part of the International Society of Travel Medicine– 12th Asia-Pacific Travel Health Conference, Thailand 21-24 March 2019
Proctor Certificate of Traveler's Health Examination (CTH), Atlanta, GA, September, 2019

PRESENTATIONS AT NATIONAL/INTERNATIONAL MEETINGS

2017- Meeting of the Colombian Society of Infectious Diseases, August 2017:
Discussion of Clinical Cases Session, Influenza, MERS-Coronavirus, Leprosy, Enteric Fever
2018 – Cutaneous Mycobacterial Diseases, Universidad Cayetano Heredia,
Lima, Peru, Mayo 2018
2018 – Scientific Writing Seminar, ACIN, Pereira, Colombia, August 2-4, 2018
2019 – First International Congress of Tropical Diseases ACINTROP 2019. March 21, 2019, Monteria, Colombia, Topic: Leishmaniasis
2019 – One Health Symposium of Zoonoses, Pereira Colombia, August 16-17, 2019, Topic: Zoonotic Leprosy
2019 – Congress Colombian Association of Infectious Diseases (ACIN), Topic: Leprosy in Latin America, Cartagena, Colombia, August 21-24, 2019
2019 – World Society Pediatric Infectious Diseases, Manila Philippines, November 7-9, 2019 - Tropical Medicine Symposium: Diagnosis, Treatment, and Prevention of Leprosy.
2019 – FLAP. Federacion Latino Americana de Parasitologia, Panama, Panama, November 26, 2019, Oral Transmission of Leprosy Symposium
2019 – FLAP. Federacion Latino Americana de Parasitologia, Panama, Panama, November 27, 2019, Leprosy Situation in the Americas.

PUBLICATIONS

BOOKS

Franco-Paredes C, Santos-Preciado JI. Neglected Tropical Diseases in Latin America and the Caribbean, Springer-Verlag, 2015. ISBN-13: 978-3709114216 ISBN-10: 3709114217
Franco-Paredes C. Core Concepts in Clinical Infectious Diseases, Academic Press, Elsevier, March 2016. ISBN: 978-0-12-804423-0

RESEARCH ORIGINAL ARTICLES (clinical, basic science, other) in refereed journals:

1. Del Rio C, **Franco-Paredes C**, Duffus W, Barragan M, Hicks G. Routinely Recommending HIV Testing at a Large Urban Urgent-Care Clinic – Atlanta, GA. *MMWR Morbid Mortal Wkly Rep* 2001; 50:538-541.
2. Del Rio C, Barragán M, **Franco-Paredes C**. *Pneumocystis carinii* Pneumonia. *N Engl J Med* 2004; 351:1262-1263.
3. Barragan M, Hicks G, Williams M, **Franco-Paredes C**, Duffus W, Del Rio C. Health Literacy is Associated with HIV Test Acceptance. *J Gen Intern Med* 2005; 20:422-425.

4. Rodriguez-Morales A, Arria M, Rojas-Mirabal J, Borges E, Benitez J, Herrera M, Villalobos C, Maldonado A, Rubio N, **Franco-Paredes C**. Lepidopterism Due to the Exposure of the Moth *Hylesia metabus* in Northeastern Venezuela. *Am J Trop Med Hyg* 2005; 73:991-993.
5. Rodriguez-Morales A, Sánchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. White Blood Cell Counts in *Plasmodium vivax*. *J Infect Dis* 2005; 192:1675-1676.
6. Franco-Paredes C, Nicolls D, Dismukes R, Kozarsky P. Persistent Tropical Infectious Diseases among Sudanese Refugees Living in the US. *Am J Trop Med Hyg* 2005; 73: 1.
7. Osorio-Pinzon J, Moncada L, **Franco-Paredes C**. Role of Ivermectin in the Treatment of Severe Orbital **Myiasis Due to *Cochliomyia hominivorax*. *Clin Infect Dis* 2006; 3: e57-9.**
8. Rodriguez-Morales A, **Franco-Paredes C**. Impact of *Plasmodium vivax* Malaria during Pregnancy in Northeastern Venezuela. *Am J Trop Med Hyg* 2006; 74:273-277.
9. Rodriguez-Morales A, Nestor P, Arria M, **Franco-Paredes C**. Impact of Imported Malaria on the Burden of Malaria in Northeastern Venezuela. *J Travel Med* 2006; 13:15-20.
10. Rodríguez-Morales A, Sánchez E, Vargas M, Piccolo C, Colina R, Arria M, **Franco-Paredes C.** Is anemia in *Plasmodium vivax* More Severe and More Frequent than in *Plasmodium falciparum? Am J Med* 2006; 119:e9-10.
11. Hicks G, Barragan M, **Franco-Paredes C**, Williams MV, del Rio C. Health Literacy is a Predictor of HIV Knowledge. *Fam Med J* 2006; 10:717-723.
12. Cardenas R, Sandoval C, Rodriguez-Morales A, **Franco-Paredes C**. Impact of Climate Variability in the Occurrence of Leishmaniasis in Northeastern Colombia. *Am J Trop Med Hyg* 2006; 75:273-7.
13. Franco-Paredes C, Nicolls D, Dismukes R, Wilson M, Jones D, Workowski K, Kozarsky P. Persistent and Untreated Tropical Infectious Diseases among Sudanese Refugees in the US. *Am J Trop Med Hyg* 2007; 77:633-635.
14. Rodríguez-Morales AJ, Sanchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. Hemoglobin and haematocrit: The Threefold Conversion is also Non Valid for Assessing Anaemia in *Plasmodium vivax* Malaria-endemic Settings. *Malaria J* 2007; 6:166.
15. Franco-Paredes C, Jones D, Rodriguez-Morales AJ, Santos-Preciado JI. Improving the Health of Neglected Populations in Latin America. *BMC Public Health* 2007; 7.
16. Kelly C, Hernández I, **Franco-Paredes C**, Del Rio C. The Clinical and Epidemiologic Characteristics of Foreign-born Latinos with HIV/AIDS at an Urban HIV Clinic. *AIDS Reader* 2007; 17:73-88.
17. Hotez PJ, Bottazzi ME, **Franco-Paredes C**, Ault SK, Roses-Periago M. The Neglected Tropical Diseases of Latin America and the Caribbean: Estimated Disease Burden and Distribution and a Roadmap for Control and Elimination. *PLoS Negl Trop Dis* 2008; 2:e300.
18. Tellez I, Barragan M, Nelson K, Del Rio C, **Franco-Paredes C**. *Pneumocystis jiroveci* (PCP) in the Inner City: A Persistent and Deadly Pathogen. *Am J Med Sci* 2008; 335:192-197.
19. Rodriguez-Morales AJ, Olinda, **Franco-Paredes C**. Cutaneous Leishmaniasis Imported from Colombia to Northcentral Venezuela: Implications for Travel Advice. *Trav Med Infect Dis* 2008; 6(6): 376-9.
20. Jacob J, Kozarsky P, Dismukes R, Bynoe V, Margoles L, Leonard M, Tellez I, **Franco-Paredes C**. Five-Year Experience with Type 1 and Type 2 Reactions in Hansen's Disease at a US Travel Clinic. *Am J Trop Med Hygiene* 2008; 79:452-454.
21. Delgado O, Silva S, Coraspe V, Ribas MA, Rodriguez-Morales AJ, Navarro P, **Franco-Paredes C**. Epidemiology of Cutaneous Leishmaniasis in Children and Adolescents in Venezuela. *Trop Biomed.* 2008; 25(3):178-83.

22. Franco-Paredes C, Lammoglia L, Hernandez I, Santos-Preciado JI. Epidemiology and Outcomes of Bacterial Meningitis in Mexican Children: 10-Years' Experience (1993-2003). *Int J Infect Dis* 2008; 12:380-386.
23. Pedroza A, Huerta GJ, Garcia ML, Rojas A, Lopez I, Peñagos M, **Franco-Paredes C**, Deroche C, Mascareñas C. The Safety and Immunogenicity of Influenza Vaccine in Children with Asthma in Mexico. *Int J Infect Dis* 2009; 13(4): 469-75.
24. Museru O, **Franco-Paredes C**. Epidemiology and Outcomes of Hepatitis B Virus Infection among Refugees Seen at U.S. Travel Medicine Clinic: 2005-2008. *Travel Med Infect Dis* 2009; 7: 171-179.
25. Rodriguez-Morales AJ, Olinda M, **Franco-Paredes C**. Imported Cases of Malaria Admitted to Two Hospitals of Margarita Island, Venezuela: 1998-2005. *Travel Med Infect Dis* 2009: (1): 48-45.
26. Kelley CF, Checkley W, Mannino DM, **Franco-Paredes C**, Del Rio C, Holguin F. Trends in Hospitalizations for AIDS-associated *Pneumocystis jiroveci* Pneumonia in the United States (1986-2005). *Chest* 2009; 136(1): 190-7.
27. Carranza M, Newton O, **Franco-Paredes C**, Villasenor A. Clinical Outcomes of Mexican Children with Febrile Acute Upper Respiratory Infection: No Impact of Antibiotic Therapy. *Int J Infect Dis* 2010; 14(9): e759-63.
28. Museru O, Vargas M, Kinyua M, Alexander KT, **Franco-Paredes C,** Oladele A. Hepatitis B Virus Infection among Refugees Resettled in the U.S.: High Prevalence and Challenges in Access to Health Care. ***J Immigrant Minor Health* 2010;**
29. Moro P, Thompson B, Santos-Preciado JI, Weniger B, Chen R, **Franco-Paredes C.** Needlestick injuries in Mexico City sanitation workers. *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* 2010; 27 (6): 467-8.
30. Barragan M, Holtz M, **Franco-Paredes C**, Leonard M. The Untimely Misfortune of Tuberculosis Diagnosis at time of Death. *Infect Dis Clin Pract* 2010; 18(6):1-7.
31. Hochberg N, Armstrong W, Wang W, Sheth A, Moro R, Montgomery S, Steuer F, Lennox J, **Franco-Paredes C**. High Prevalence of Persistent Parasitic Infections in Foreign-born HIV-infected Persons in the United States. *PLoS Neglect Dis* 2011; 5(4): e1034.
32. Larocque RC, Rao SR, Lee J, Ansdell V, Yates JA, Schwartz BS, Knouse M, Cahill J, Hagmann S, Vinetz J, Connor BA, Goad JA, Oladele A, Alvarez S, Stauffer W, Walker P, Kozarsky P, **Franco-Paredes C**, Dismukes R, Rosen J, Hynes NA, Jacquerioz F, McLellan S, Hale D, Sofarelli T, Schoenfeld D, Marano N, Brunette G, Jentes ES, Yanni E, Sotir MJ, Ryan ET; the Global TravEpiNet Consortium. Global TravEpiNet: A National Consortium of Clinics Providing Care to International Travelers--Analysis of Demographic Characteristics, Travel Destinations, and Pretravel Healthcare of High-Risk US International Travelers, 2009-2011. *Clin Infect Dis*. 2012; 54(4):455-462.
33. Espinosa-Padilla SE, Murata C, Estrada-Parra S, Santos-Argumendo L, Mascarenas C, **Franco-Paredes C**, Espinosa-Rosales FJ. Immunogenicity of a 23-valent pneumococcal polysaccharide vaccine among Mexican children. *Arch Med Res* 2012;
34. Harris JR, Lockhart SR, Sondermeyer G, Vugia DJ, Crist MB, D'Angelo MT, Sellers B, **Franco-Paredes C**, Makvandi M, Smelser C, Greene J, Stanek D, Signs K, Nett RJ, Chiller T, Park BJ. *Cryptococcus gattii* infections in multiple states outside the US Pacific Northwest. *Emerg Infect Dis*. 2013; 19 (10):1620-6.
35. Franco-Paredes C. Aerobic actinomycetes that masquerade as pulmonary tuberculosis. Bol Med Hosp Infant Mex 2014; 71(1): 36-40.
36. Chastain DB, Ngando I, Bland CM, **Franco-Paredes C**, and Hawkins WA. Effect of the 2014 Clinical and Laboratory Standard Institute urine-specific breakpoints on cefazolin susceptibility rates at a community teaching hospital. *Ann Clin Microbiol Antimicrob* 2017; 16(1): 43.

37. Kashef Hamadani BH, **Franco-Paredes C**, MCollister B, Shapiro L, Beckham JD, Henao-Martinez AF. Cryptococcosis and cryptococcal meningitis- new predictors and clinical outcomes at a United States Academic Medical Center. *Mycoses* 2017; doi: 10.1111/myc.12742.
38. Chastain DB, **Franco-Paredes C**, Wheeler SE, Olubajo B, Hawkins A. Evaluating Guideline Adherence regarding Empirical Vancomycin use in patients with neutropenic fever. *Int J Infect Dis* 2018; Feb 22. pii: S1201-9712(18)30052-3. doi: 10.1016/j.ijid.2018.02.016. PMID: 29477362
39. Parra-Henao G, Amioka E, **Franco-Paredes C**, Colborn KL, Henao-Martinez AF. Heart failure symptoms and ecological factors as predictors of Chagas disease among indigenous communities in the Sierra Nevada de Santa Marta, Colombia. *J Card Fail* 2018; Mar 26. pii: S1071-9164(18)30119-2. doi: 10.1016/j.cardfail.2018.03.007.
40. Vela Duarte D, Henao-Martinez AF, Nyberg E, Castellanos P, **Franco-Paredes C**, Chastain DB, Lacunar Stroke in Cryptococcal Meningitis: Clinical and Radiographic Features. *J Stroke and Cerebrovascular Disease* 2019;
41. Chastain DB, Henao-Martinez AF, **Franco-Paredes C**. A clinical pharmacist survey of prophylactic strategies used to prevent adverse events of lipid-associated formulations of amphotericin B. *Infect Dis* 2019;
42. Henao-Martínez AF, Chadalawada S, Villamil-Gomez WE, DeSanto K, Rassi A Jr, **Franco-Paredes C**. Duration and determinants of Chagas latency: an etiology and risk systematic review protocol. *JBI Database System Rev Implement Rep*. 2019 Jul 22. doi: 10.11124/JBISRIR-D-18-00018.

CONSENSUS STATEMENTS

Pritchett MA, Oberg CL, Belanger A, De Cardenas J, Cheng G, Cumbo Nacheli G, **Franco-Paredes C,** Singh J, Toth J, Zgoda M, Folch E. Society for Advanced Bronchoscopy Consensus Statement and Guidelines for bronchoscopy and airway management amid the COVID-19 pandemic. *J Thorac Dis* 2020; http:/dx.doi.org/10.21037/jtd.2020.04.32

RESEARCH ORIGINAL ARTICLES AS COLLABORATOR (clinical, basic science, other) in refereed journals:
43. Benator D, Bhattacharya M, Bozeman L, Burman W, Cantazaro A, Chaisson R, Gordin F, Horsburgh CR, Horton J, Khan A, Lahart C, Metchock B, Pachucki C, Stanton L, Vernon A, Villarino ME, Wang YC, Weiner M, Weis S; **Tuberculosis Trials Consortium**. Rifapentine and Isoniazid Once a Week versus Rifampicin and Isoniazid twice a week for Treatment of Drug-susceptible Pulmonary Tuberculosis in HIV-Negative Patients: a Randomised Clinical Trial. *Lancet* 2002; 360:528-34.
44. Weiner M, Burman W, Vernon A, Benator D, Peloquin CA, Khan A, Weis S, King B, Shah N, Hodge T; **Tuberculosis Trials Consortium**. Low INH Concentrations and Outcome of Tuberculosis Treatment with Once-weekly INH and Rifapentine. *Am J Rev Crit Care Med* 2003; 167:1341-1347.
45. Jasmer RM, Bozeman L, Schwartzman K, Cave MD, Saukkonen JJ, Metchock B, Khan A, Burman WJ; **Tuberculosis Trials Consortium**. Recurrent Tuberculosis in the United States and Canada: Relapse or Reinfection? *Am J Respir Crit Care Med* 2004; 170:1360-1366.
Mendelson M, Davis XM, Jensenius M, Keystone JS, von Sonnenburg F, Hale DC, Burchard GD, Field V, Vincent P, Freedman DO; **GeoSentinel Surveillance Network**. Health risks in travelers to South Africa:

the GeoSentinel experience and implications for the 2010 FIFA World Cup. *Am J Trop Med Hyg*. 2010; 82(6): 991-5.
46. Hagmann S, Neugebauer R, Schwartz E, Perret C, Castelli F, Barnett ED, Stauffer WM; GeoSentinel Surveillance Network. Illness in children after international travel: analysis from the **GeoSentinel Surveillance Network**. *Pediatrics.* 2010; 1 25(5): e1072-80.
47. Schlagenhauf P, Chen LH, Wilson ME, Freedman DO, Tcheng D, Schwartz E, Pandey P, Weber R, Nadal D, Berger C, von Sonnenburg F, Keystone J, Leder K; **GeoSentinel Surveillance Network**. Sex and gender differences in travel-associated disease. *Clin Infect Dis*. 2010; 50 (6): 826-32.
48. Jensenius M, Davis X, von Sonnenburg F, Schwartz E, Keystone JS, Leder K, Lopéz-Véléz R, Caumes E, Cramer JP, Chen L, Parola P; **GeoSentinel Surveillance Network**. Multicener GeoSentinel analysis of rickettsial diseases in international travelers, 1996-2008. *Emerg Infect Dis*. 2009; 15(11):1791-8.
49. Chen LH, Wilson ME, Davis X, Loutan L, Schwartz E, Keystone J, Hale D, Lim PL, McCarthy A, Gkrania-Klotsas E, Schlagenhauf P; **GeoSentinel Surveillance Network**. *Emerg Infect Dis*. 2009; 15(11): 1773-82.
50. Nicolls DJ, Weld LH, Schwartz E, Reed C, von Sonnenburg F, Freedman DO, Kozarsky PE; **GeoSentinel Surveillance Network**. Characteristics of schistosomiasis in travelers reported to the GeoSentinel Surveillance Network 1997-2008. *Am J Trop Med Hyg 2008*; 79(5): 729-34.
51. Greenwood Z, Black J, Weld L, O'Brien D, Leder K, Von Sonnenburg F, Pandey P, Schwartz E, Connor BA, Brown G, Freedman DO, Torresi J; **GeoSentinel Surveillance Network.** Gastrointestinal infection among international travelers globally. *J Travel Med* 2008; 1 5(4):221-8.
52. Davis XM, MacDonald S, Borwein S, Freedman DO, Kozarsky PE, von Sonnenburg F, Keystone JS, Lim PL, Marano N; **GeoSentinel Surveillance Network**. Health risks in travelers to China: the GeoSentinel experience and implications for the 2008 Beijing Olympics. *Am J Trop Med Hyg* 2008; 79(1): 4-8.
53. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Vaccine preventable diseases in returned international travelers: results from the GeoSentinel Surveillance Network. *Vaccine* 2010; 28(46):7389-95.
54. Esposito DH, Han PV, Kozarsky PE, Walker PF, Gkrania-Klotsas E, Barnett ED, Libman M, McCarthy AE, Field V, Connor BA, Schwartz E, MacDonald S, Sotir MJ; **GeoSentinel Surveillance Network**. Characteristics and spectrum of disease among ill returned travelers from pre- and post-earthquake Haiti: The GeoSentinel experience. *Am J Trop Med Hyg* 2012 Jan; 86(1):23-8.
55. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Latitudinal patterns of travel among returned travelers with influenza: results from the GeoSentinel Surveillance Network, 1997-2007. *J Travel Med* 2012; 19(1):4-8. doi: 10.1111/j.1708-8305.2011.00579.x.

REVIEW, EDITORIALS, CASE SERIES, CASE REPORT ARTICLES:

56. Franco-Paredes C, Jurado R. Ankylosing Spondylitis Fibrocavitary Lung Disease. *Clin Infect Dis* 2001; 32:1062.

57. Franco-Paredes C, Evans J, Jurado R. Diabetes Insipidus due to *Streptococcus pneumoniae* Meningitis. *Arch Intern Med* 2001; 161; 1114-15.
58. Franco-Paredes C, Blumberg H. Tuberculosis Psoas Abscess caused by *Mycobacterium tuberculosis* and *Staphylococcus aureus*: Case Report and Review. *Am J Med Sci* 2001; 321:415-17.
59. Jurado R, **Franco-Paredes C**. Aspiration Pneumonia: A Misnomer. *Clin Infect Dis* 2001;33:1612-3.
60. Del Rio Carlos, **Franco-Paredes C**. Bioterrorism: A New Public Health Problem. *Sal Publ Mex* 2001; 43:585-88.
61. Franco-Paredes C, Blumberg H. New Concepts in the Diagnosis of Latent Tuberculosis Infection. *Consultant* 2001; 41:1105-1121.
62. Franco-Paredes C, Bellehemeur T, Sanghi P, et al. Aseptic Meningitis and Retrobulbar Optic Neuritis Caused By VZV Preceding the Onset of PORN in a Patient with AIDS. *AIDS* 2002; 16:1045-1049.
63. Franco-Paredes C, Mehrabi D, Calle J, Jurado R. Night Sweats Revisited. *Infect Dis Clin Pract* 2002; 11:291-293.
64. Franco-Paredes C, Jurado R, Del Rio C. The Clinical Utility of the Urine Gram Stain. *Infect Dis Clin Pract* 2002; 11:561-563.
65. Franco-Paredes C, Agudelo C. Editorial Response: The Ever Expanding Clinical Spectrum of Tuberculosis. *J Clin Rheumatol* 2002;8:1-2.
66. Franco-Paredes C, Rebolledo P, Folch E, Hernandez I, Del Rio C. Diffuse CD8 Lymphocytosis Syndrome in HIV-infected Patients. *AIDS Reader* 2002; 12:408-13.
67. Franco-Paredes C. Human Immunodeficiency Virus Infection as a Risk Factor for Tuberculosis Infection and Clinical Disease. *Infect Med* 2002; 19:475-479.
68. Franco-Paredes C, Leonard M, Jurado R, Blumberg H. Tuberculosis of the Pancreas. Report of two cases and Review of the Literature. *Am J Med Sci* 2002; 323(1): 54-58.
69. DiazGranados C, **Franco-Paredes C**, Steinberg J. A Long Suffering Patient with New Abdominal Pain. *Clin Infect Dis* 2002; 34(9):1213-1214; 1267-1268.
70. Franco-Paredes C, Martin K. Extranodal Rosai-Dorfman Manifested in the Meninges. *Southern Med J* 2002; 95(9): 1101-1104.
71. Franco-Paredes C, Workowski K, Harris M. Infective Endocarditis-Endarteritis Complicating Coarctation of the Aorta. *Am J Med* 2002; 112(7):590-92.
72. Folch E, Hernandez I, Barragan M, **Franco-Paredes C**. Infectious Disease, Non-Zero Sum Thinking and the Developing World. *Am J Med Sci* 2003; 326:66-72.
73. Franco-Paredes C, Santos Preciado JI. Parasitology Resources on the World Wide Web: A Powerful Tool for Infectious Diseases Practitioners. *Clin Infect Dis* 2003; 37:694-701.
74. Franco-Paredes C, Tellez I, Santos-Preciado JI. *Monkeypox* Virus Infection Appears in the Americas. *Salud Publ Mex* 2003; 45:428-430.
75. Franco-Paredes C, Del Rio C, Nava Frías M, Rangel Frausto S, Téllez I, Santos Preciado JI. Confronting Bioterrorism: Epidemiologic, Clinical, and Preventive Aspects of Smallpox. *Sal Publ Mex* 2003; 45:298-309.
76. Franco-Paredes C, Kuri-Morales P, Alvarez-Lucas C, Zavala E, Betancourt M, Nava-Frias M, Santos-Preciado JI. Severe Acute Respiratory Syndrome: A Global View of the Epidemic. *Sal Publ Mex* 2003; 45:211-220.
77. Huneycut D, Folch E, **Franco-Paredes C**. Atypical Manifestations of Infections in Patients with Familial Dysautonomia. *Am J Med* 2003; 115(6): 505-506.
78. Franco-Paredes C, Sanghi P. Progressive Multifocal Leukoencephalopathy. *Infect Med* 2003; 20(8):376.

79. Franco-Paredes C, Guarner J, McCall C, Mehrabi D, Del Rio C. Clinical and Pathological Recognition of Leprosy. *Am J Med* 2003; 114(3):246-7.
80. Franco-Paredes C, Lammoglia L, Santos Preciado JI. Historical Perspective of Smallpox in Mexico: Origins, Elimination, and Risk of Reintroduction due to Bioterrorism. *Gac Med Mex* 2004; 141:321-328.
81. Santos-Preciado JI, **Franco-Paredes C**. Influenza Vaccine in Childhood: a Preventive Strategy of National Priority. *Salud Publ Mex* 2004; 46:498-500.
82. Almeida L, **Franco-Paredes C**, Pérez LF, Santos JI. Meningococcal Disease: Preventive and Clinical Aspects. *Salud Publ Mex* 2004; 46(5):438-50.
83. Franco-Paredes C, Téllez I, Del Rio C. The Inverse Relationship between Decreased Infectious Diseases and Increased Inflammatory Disease Occurrence. *Arch Med Res* 2004; 35:258-26.
84. Arria M, Rodríguez-Morales A, **Franco-Paredes C**. Galeria Eco-epidemiológica de la Cuenca Amazónica. *Rev Peru Salud Publ* 2005; 22:236-240.
85. Franco-Paredes C, Lammoglia L, Santos-Preciado JI. The Spanish Royal Philanthropic Expedition to Bring Smallpox Vaccination to the New World and Asia in the 19th Century. *Clin Infect Dis* 2005; 41:1285-1289.
86. Diaz-Borjon A, Lim S, **Franco-Paredes C**. Multifocal Septic Arthritis: An Unusual Complication of Invasive *Streptococcus pyogenes* Infection. *Am J Med* 2005. 118(8): 924-925.
87. Franco-Paredes C, Rodríguez A. Lepromatous Leprosy. *Infect Med* 2005
88. Santos-Preciado JI, **Franco-Paredes C**. Tratamiento Acortado Estrictamente Supervisado (TAES o DOTS) Para Tuberculosis en Poblaciones Con Niveles Moderados de Farmacorresistencia: Perspectiva del Impacto Internacional. *Rev Inv Clin* 2005; 57:488-490.
89. Rodríguez-Morales A, Sánchez E, Vargas M, Piccolo C, Colina R, Arria M, **Franco-Paredes C**. Severe Thrombocytopenia, Reply to Spinello et al. *Clin Infect Dis* 2005; 41:1211-1212.
90. Franco-Paredes C, Dismukes R, Nicolls D, Kozarsky P. Reply to Newton et al. *Clin Infect Dis* 2005;41:1688-1689.
91. Rodríguez-Morales A, Sánchez E, Vargas M, Piccolo C, Colina R, Arria M, **Franco-Paredes C**. Occurrence of Thrombocytopenia in *Plasmodium vivax* malaria. *Clin Infect Dis* 2005;41:130-131.
92. Franco-Paredes C, Rodríguez-Morales A, Santos-Preciado JI. Bioterrorism: Preparing for the Unexpected. *Rev Inv Clin* 2005; 57: 57(5):695-705.
93. Franco-Paredes C, Tellez I, Del Rio C, Santos-Preciado JI. Pandemic Influenza: Impact of Avian Influenza. *Salud Publ Mex* 2005; 2: 47(2):107-9.
94. Franco-Paredes C, Dismukes R, Nicolls D, Kozarsky D. Neurotoxicity Associated To Misdiagnosis of Malaria. *Clin Infect Dis* 2005; 40:1710-1711.
95. Rodríguez-Morales A, Benitez J, **Franco-Paredes C**. *Plasmodium vivax* Malaria Imported from a rural Area Near Caracas Venezuela? *J Trav Med* 2006; 13:325-326.
96. Franco-Paredes C, Tellez I, Del Rio C. Rapid HIV Testing. *Current HIV/AIDS Reports* 2006; 3:169-75.
97. Franco-Paredes C, Hidron A, Steinberg JP. Photo Quiz: An 82-year-old Female from Guyana with Fever and Back pain. Chyluria due to *Wuchereria bancrofti* Infection. *Clin Infect Dis* 2006; 42 (9): 1297; 1340-1341.
98. Franco-Paredes C, Kozarsky P, Nicolls D, Dismukes R. Pelvic Echinococcosis in a Northern Iraqi Refugee. *J Trav Med* 2006. 13 (2): 119-122.
99. Franco-Paredes C, Santos-Preciado JI. Prevention of Malaria in Travelers. *Lancet Infect Dis* 2006; 6:139-149.
100. Franco-Paredes C, Santos-Preciado JI. Reply to Christenson. *Clin Infect Dis* 2006; 42: 731-732.

101. Franco-Paredes C, Diaz-Borjon A, Barragán L, Senger M, Leonard M. The Ever Expanding Association between Tuberculosis and Rheumatologic Diseases. *Am J Med* 2006; 119:470-477.
102. **Franco-Paredes C**, Rouphael N, Del Rio C, Santos-Preciado JI. Vaccination Strategies to Prevent Tuberculosis in the New Millennium: From BCG to New Vaccine Candidates. *Int J Infect Dis* 2006; 10:93-102.
103. Tellez I, Calderon O, **Franco-Paredes C**, Del Rio C. West Nile Virus: A Reality in Mexico. *Gac Med Mex* 2006; 142:493-9.
104. Franco-Paredes C, Santos-Preciado JI. Reply to Christenson. *Clin Infect Dis* 2006; 42:731-732.
105. Kieny MP, Costa A, Carrasco P, Perichov Y, **Franco-Paredes C**, Santos-Preciado JI, et al. A Global Pandemic Influenza Vaccine Action Plan. *Vaccine* 2006; 24:6367-6370.
106. Franco-Paredes C, Anna Von, Alicia Hidron, Alfonso J. Rodríguez-Morales, Ildefonso Tellez, Maribel Barragán, Danielle Jones, Cesar G. Náquira, Jorge Mendez. Chagas Disease: An Impediment in Achieving the Millennium Development Goals in Latin America. *BMC Int Health Hum Rights* 2007; 7:7.
107. Von A, Zaragoza E, Jones D, Rodriguez-Morales A, **Franco-Paredes C**. New Insights into Chagas Disease: A Neglected Disease in Latin America. *J Infect Developing Countries* 2007; 1:99-111.
108. Tellez I, **Franco-Paredes C**, Caliendo A, Del Rio C. Rapid HIV Test: A Primer for Clinicians. *Infect Med* 2007; 24:381-385.
109. Franco-Paredes C, Rouphael N, Rodríguez-Morales A, Folch E, Mendez N, Hurst JW. Cardiac Manifestations of Parasitic Diseases Part 1. General Aspects and Immunopathogenesis. *Clin Cardiol* 2007; 30:195-199.
110. Franco-Paredes C, Rouphael N, Rodríguez-Morales A, Folch E, Mendez N, Hurst JW. Cardiac Manifestations of Parasitic Diseases Part 2. Myocardial Manifestations of Parasitic Diseases. *Clin Cardiol* 2007; 30:218-222.
111. Franco-Paredes C, Rouphael N, Rodríguez-Morales A, Folch E, Mendez N, Hurst JW. Cardiac Manifestations of Parasitic Diseases Part 3. Pericardial Manifestations of Parasitic Diseases and Other Cardiopulmonary Manifestations. *Clin Cardiol* 2007; 30:277-280.
112. Rouphael N, Talati N, **Franco-Paredes C**. A Painful Thorn in the Foot: Eumycetoma. *Am J Med Sci* 2007; 334:142-144.
113. Zimmer S, **Franco-Paredes C**. Efficacy of Nitazoxanide in the Treatment of *Cyclospora cayetanensis* in a Patient Allergic to Sulfas. *Clin Infect Dis* 2007; 44(3):466-7.
114. Kaplan R, Rebolledo P, Gonzalez E, **Franco-Paredes C**. An Unexpected Visitor: *Mycobacterium kansasii* Cutaneous Infection. *Am J Med* 2007; 120(5):415-6.
115. Seybold U, Blumberg H, Talati N, **Franco-Paredes C**. Hematogenous Osteomyelitis Mimicking Osteosarcoma due to Community Associated Methicillin-Resistant *Staphylococcus aureus*. *Infect* 2007; 35(3): 190-3.
116. Liff D, Kraft C, Pohlel K, Sperling L, Chen E, **Franco-Paredes C**. *Nocardia Nova* Aortitis Following Coronary Artery Bypass Surgery. *J Am Soc Echo* 2007; 20(5):537:e7-8.
117. Rodriguez-Morales AJ, **Franco-Paredes C**. Paracoccidiodomycosis (South American Blastomycosis) of the Larynx Mimicking Carcinoma. *Am J Med Sci* 2008; 335:149-150.
118. Franco-Paredes C. Filariasis due *Loa loa* is also a cause of Angioedema. *Am J Med* 2008; 121(10): e29.
119. Rodriguez-Morales A, Benitez J, Tellez I, **Franco-Paredes C**. Chagas Disease Screening among Latin American Immigrants in Non-endemic Settings. *Travel Medicine and Infectious Disease* 2008; 6:162-3.
120. Talati N, Rouphael N, Kuppali K, **Franco-Paredes C**. Spectrum of Central Nervous System Manifestations due to Rapidly Growing *Mycobacteria*. *Lancet Infect Dis* 2008; 8:390-8.

121. Rifakis P, Rodríguez-Morales A, **Franco-Paredes C**. Atypical *Plasmodium vivax* Malaria in a Traveler: Bilateral hydronephrosis, Severe Thrombocytopenia, and Hypotension. *J Trav Med* 2008; 15(2): 119-21.
122. Osorio-Pinzon J, Carvajal C, Sussman O, Buitrago R, **Franco-Paredes C**. Acute liver failure due to dengue virus infection. *Int J Infect Dis* 2008; 12: 444-445.
123. Jacob J, **Franco-Paredes C**. The Stigmatization of leprosy in India and its Impact on future approaches to elimination and control. *PloS Neglected Tropical Diseases* 2008; 30:e113.
124. Difrancesco L, Mora L, Doss M, Small J, Williams M, **Franco-Paredes C**. Short of Breath: Not short of diagnosis. *J Hosp Med* 2009; 4(1):60-7.
125. Whitaker JA, Edupuganti S, Del Rio C, **Franco-Paredes C**. Rethinking Typhoid Fever Vaccines: Implications for travelers and those living in endemic areas. *J Travel Med* 2009, 16(1): 46-52.
126. Franco-Paredes C, Hidron A, Lesesne J, Tellez I, Del Rio C. HIV-AIDS: Pretravel recommendations and health-related risks. *Topics in HIV* 2009; 17(1): 2-11.
127. Franco-Paredes C, Jacob JT, Stryjewska B, Yoder L. Two patients with leprosy and the sudden appearance of Inflammation in the skin and new sensory loss. *PLoS Negl Trop Dis* 2009; 3(9): e425.
128. Franco-Paredes C, Hidron A, Jacob J, Nicolls D, Kuhar D, Caliendo A. Transplantation and Tropical Infectious Diseases. *Int J Infect Dis* 2009; 14(3): e189-96.
129. Parker S, Vogenthaler N, **Franco-Paredes C**. *Leishmania tropica* Cutaneous and Presumptive Concomitant Viscerotropic Leishmaniasis with Prolonged Incubation. *Arch Dermatol* 2009; 145(9): 1023-6.
130. DiazGranados C, **Franco-Paredes C**. HIV and Chagas Disease Co-Infection: An Evolving Epidemiologic and Clinical Association. *Lancet Infect Dis* 2009; 9:324-330.
131. Hidron A, **Franco-Paredes C**, Drenkard C. A rare opportunistic infection in a woman with systemic lupus erythematous and multiple skin lesions. *Lupus* 2009; 18 (12): 1100-3.
132. Franco-Paredes C, Kozarsky P. The Bottom Line. *Am J Med* 2009; 122(12): 1067-8.
133. Franco-Paredes C, Bottazzi ME, Hotez PJ. The Unfinished Agenda of Chagas Disease Control in the Era of Globalization. *PLoS Negl Trop Dis.* 2009 Jul 7; 3(7): e470.
134. Franco-Paredes C, Carrasco P, Del Rio C, Santos Preciado JI. Respuesta al Brote de Influenza A H1N1. *Salud Publ Mex* 2009; 51 (3): 183-186.
135. Franco-Paredes C. An Unusual Clinical Presentation of Posttraumatic Stress Disorder in a Sudanese Refugee. *Journal of Immigrant and Minority Health* 2009; 12(2): 267-9.
136. Kempker R**,** DiFrancesco L, Gorgojo A, **Franco-Paredes C**. Xantogranulomathous pyelonephritis caused by Community-Associated MRSA. *Cases Journal* 2009; 2: 7437.
137. Franco-Paredes C, Carrasco P, Santos-Preciado JI. The First Influenza Pandemic in the New Millennium: Lessons Learned Hitherto for Current Control Efforts and Overall Pandemic Preparedness. *Journal of Immune Based Therapies and Vaccines* 2009, 7:2.
138. Livorsi D, Qureshi S, Howard M, **Franco-Paredes C**. Brainstem Encephalitis: An Unusual Presentation of Herpes Simplex Virus Infection. *J Neurol* 2010; 257(9): 1432-7.
139. Del Rio C, **Franco-Paredes C**. The Perennial threat of influenza viruses: The Mexican Experience during the Influenza A (H1N1) 2009 Pandemic. *Arch Med Res* 2010; 40(8):641-2.

140. Santos-Preciado JI, **Franco-Paredes C**, Hernandez-Ramos MI, Tellez I, Del Rio C, Roberto Tapia-Conyer R. What have we learned from the Novel Influenza A (H1N1) Influenza Pandemic in 2009 for strengthening Pandemic Influenza Preparedness? *Arch Med Res* 2010; 40(8): 673-6.
141. Franco-Paredes C, Hernandez-Ramos MI, Del Rio C, Alexander KT, Tapia-Conyer R, Santos-Preciado JI. H1N1 Influenza Pandemics: Comparing the Events of 2009 in Mexico with those of 1976, and 1918-1919. *Arch Med Res* 2010; 40(8): 6730-6.
142. Graham A, Furlong S, Owusu K, Margoles L, **Franco-Paredes C.** Clinical Management of Leprosy Reactions. *Infect Dis Clin Prac*t 2010; 18: 234-7.
143. Hidron A, Vogenthaler N, Santos-Preciado JI, Rodriguez-Morales AJ, **Franco-Paredes C,** Rassi A. Cardiac Involvement with Parasitic Diseases. *Clin Microb Rev* 2010; 23 (2): 1-27.
144. Franco-Paredes C, Zeuli J, Hernandez-Ramos I, Santos-Preciado JI. Preserving Idealism in Global Health. *Global Health Prom* 2010; 17(4): 57-60.
145. Franco-Paredes C. Reconstructing the Past of Poliovirus Eradication. *Lancet Infect Dis* 2010; 10(10): 660-1.
146. Franco-Paredes C, Ko AI, Aksoy S, Hotez PJ. A New Clinical Section in PLoS Neglected Tropical Diseases: NTD Photo Quiz. *PLoS Neglect Trop Dis* 2010; 4(9): e760.
147. Tellez I, **Franco-Paredes** C. Actinomycetoma. *PLoS Neglect Trop Dis* 2010; 4(9): e772.
148. Franco-Paredes C, Hernandez I, Santos-Preciado JI. Equidad en inmunizaciones en las poblaciones más vulnerables en Mesoamérica: Plan Regional del Sistema Mesoamericano de Salud Pública. *Salud Publ. Mex* 2011; 53 Suppl 3:S323-32.
149. Santos-Preciado JI, Rodriguez MH, **Franco-Paredes C**. Equidad en Salud en America Latina: De la Oficina Panamericana de Salud Pública a la Iniciativa de Salud Pública. *Salud Publ. Mex* 2011; 53 Suppl 3:S289-94.
150. Rassi A Jr., Rassi A, **Franco-Paredes C.** A Latin-American woman with palpitations, a right bundle branch block, and an apical aneursym. *PLoS Neglect Trop Dis* 2011; 5(2):e852. doi: 10.1371/journal.pntd.0000852.
151. Gupta D, Green J, **Franco-Paredes C**, Lerakis S. Challenges in the Clinical Management of Blood-Culture Negative Endocarditis: the case of *Bartonella henselae* infection. *Am J Med* 2011; 124(3):e1-2. doi: 10.1016/j.amjmed.2010.09.022.
152. Franco-Paredes C. Health Equity is not only Healthcare Delivery. *Lancet* 2011; 377: 1238.
153. Franco-Paredes C, Santos-Preciado JI. Freedom, Justice, and the Neglected Tropical Diseases. *PLoS Neglect Trop Dis* 2011; 5(8):e1235.
154. Sellers B, Hall P, Cine-Gowdie S, Hays AL, Patel K, Lockhart SR, **Franco-Paredes C**. *Cryptococcus gattii:* An Emerging Fungal Pathogen in the Southeastern United States. *Am J Med Sci*. 2012; 343(6):510-1. doi: 10.1097/MAJ.0b013e3182464bc7.
155. Franco-Paredes C. Poliovirus eradication. *Lancet Infect Dis* 2012; 12(6):432-3. doi: 10.1016/S1473-3099(12)70102-0.
156. Franco-Paredes C, Ray S. Causes of persistent of acid-fast positive smears in patients with pulmonary tuberculosis. *Am J Med 2012*; 125(12):e3-4. doi: 10.1016/j.amjmed.2012.03.002.

157. Franco-Paredes C. Causes of persistent of acid-fast positive smears in patients with pulmonary tuberculosis. *Am J Med* 2013: 126(7):e17. doi: 10.1016/j.amjmed.2013.03.001.
158. Franco-Paredes C. Illness and Death in the Universe. *Perm J*. 2013; 17(4):90-1.
159. Hare A, **Franco-Paredes C.** Ocular Larva Migrans: A Severe Manifestation of an Unseen Epidemic. *Curr Trop Med Rep* 2014; 1: 69-73.
160. Franco-Paredes C. Recovering our Human Story. *J Cosmology and Philosophy* 2014;12: 210-213.
161. Powell DR, Patel S, **Franco-Paredes C**. Varicella-Zoster virus vasculopathy: The growing association between herpes zoster virus and strokes. *Am J Med Sci* 2014; 350(3):243-5.
162. Franco-Paredes C. The growing threat of leishmaniasis in travelers. *Trav Med Infect Dis* 2014; 12(6 Pt A):559-60. doi: 10.1016/j.tmaid.2014.10.020.
163. Franco-Paredes C, Sellers B, Hayes A, Chane T, Patel K, Lockhart S, Marr K. Management of *Cryptococcus gattii* meningoencephalitis. *Lancet Infect Dis* 2014; 15(3):348-55.
164. White C, **Franco-Paredes C.** Leprosy in the 21st Century. *Clin Microb Rev* 2014; 28(1): 80-94.
165. Carrasco P, **Franco-Paredes C**, Andrus J, Waller K, Maassen A, Symenouh E, Hafalia G. Inaugural conference of the International Association of Immunization Managers (IAIM), Istanbul Turkey, 3-4 March 2015; *Vaccine* 2015; 33(33):4047-50.
166. Franco-Paredes C, Rodriguez-Morales AJ. Unsolved matters in leprosy: a descriptive review and call for further research. *Ann Clin Microbiol Antimicrob* 2016; 15(1):33.
167. Rodriguez-Morales AJ, Banderia AC, **Franco-Paredes C**. The expanding spectrum of modes of transmission of Zika virus: a global concern. *Ann Clin Microbiol Antimicrob* 2016; 15:13. doi: **10.1186/s12941-016-0128-2.**
168. Khan MI, Katrinak C, Freeman A, **Franco-Paredes C**. Enteric Fever and Invasive Nontyphidal Salmonellosis – 9th International Conference on typhoid and Invasive NTS Disease, Bali, Indonesia, April 30-May 3, 2015. *Emerg Infect Dis 2016*; 22(4): doi: 10.3201/eid2204.151463.
169. Franco-Paredes C, Khan MI, Santos-Preciado JI, Gonzalez-Diaz E, Rodriguez-Morales AJ, Gotuzzo E. Enteric Fever: A Slow Reponse to An Old Plague. *PLoS Negl Trop Dis* 2016; 10(5):e0004597. doi: 10.1371/journal.pntd.0004597.
170. Rodriguez-Morales AJ, Villamil-Gomez WE, **Franco-Paredes C**. The arboviral burden of disease caused by co-circulation and co-infection of dengue, chikungunya and Zika in the Americas. *Trav Med Infect* Dis 2016; 14(3):177-9. doi: 10.1016/j.tmaid.2016.05.004.
171. Alvarado-Socarras JL, Ocampo-Gonzalez M, Vargas Soler JA, Rodriguez-Morales AJ, **Franco-Paredes C**. Congenital and neonatal Chikungunya in Colombia. *J Pediatric Infect Dis Soc*. 2016;5(3): e17-20.
172. Franco-Paredes C, Chastain DB, Ezigbo C, Callins KR. Reducing transmission of HIV in the Southeastern U.S. *Lancet HIV* 2017; 4(3):e101-e102.
173. Franco-Paredes C, Chastain D, Marcos LA, Rodriguez-Morales AJ. Cryptococcal meningoencephalitis in AIDS: When to start antiretroviral therapy? *Ann Clin Microbiol Antimicrob* 2017*;* 16:9.
174. Khan MI, **Franco-Paredes C**, Ochiai RL, Mogasale V, Sushant S. Barriers to typhoid fever vaccine access in endemic countries. *Research and Reports in Tropical Medicine*; 2017; 8:37-44.

175. Franco-Paredes C, Chastain D, Taylor P, Stocking S, Sellers B. Boar hunting and brucellosis caused by *Brucella suis*. *Trav Med Infect Dis* 2017; S1477-8939(17): 30037-6.
176. Chastain DB, Henao-Martinez AF, **Franco-Paredes C**. Cryptococcal Antigen Negative Cryptococcal Meningoencephalitis. *Diagn Microbiol Infect Dis* 2017; 89(2): 143-145.
177. Chastain DB, Henao-Martinez A, **Franco-Paredes C**. Opportunistic invasive fungal infections in HIV/AIDS: Cryptococcosis, Histoplasmosis, Coccidioidomycosis and Talaromycosis. *Current Infect Dis Rep* 2017; 19(10): 36.
178. Chastain DB, Kayla Stover, **Franco-Paredes C**. Adressing Antiretroviral Therapy-Associated Drug-Drug Interactions in Patients Requiring Treatment for Opportunistic Infections in Low-Income and Resource-Limited Settings. *J Clin Pharmacol* 2017; 57(11):1387-1399.
179. Franco-Paredes C. The Harmony of Disequilibrium. *Permanente J*. 2017; 22. doi: 10.712/TPP/17-067.
180. Franco-Paredes C, Henao-Martinez A, Chastain DB. A 27-year-old male with blurry vision, oral and nasal mucosal lesions, and a skin rash. *Clin Infect Dis* 2018;
181. Henao-Martinez AF, Olague N, **Franco-Paredes C**. Spontaneous *Mycobacterium bolletti* skin abscesses —an under recognized zoonosis from raw bovine milk. *Trav Med Infect Dis* 2018 Jan 29. pii: S1477-8939(18)30003-6. doi: 10.1016/j.tmaid.2018.01.003. PMID: 29477362.
182. Franco-Paredes C, Henao-Martinez AF, Mathur S, Villamil-Gomez W. A Man Who Harvest Peanuts with Verrucous Lesions in his Right Index Finger. *Am J Med Sci* 2018; Mar; 355(3):e7. doi: 10.1016/j.amjms.2017.11.010. Epub 2017 Nov 22. No abstract available. PMID: 2954993
183. Henao-Martinez AF, **Franco-Paredes C**, Palestine A, Montoya G. Symptomatic acute toxoplasmosis in returning travelers. *Open Forum Infect Dis* 2018;5(4):ofy058. doi: 10.1093/ofid/ofy058. eCollection 2018 Apr. PMID: 29644250.
184. Steele GM, **Franco-Paredes C**, Chastain DB. Non-infectious causes of fever in adults. *Nurse Pract* 2018Apr 19; 43(4):38-44. doi: 10.1097/01.NPR.0000531067.65817.7d.
185. Henao-Martinez AF, Chastain DB, **Franco-Paredes C**, Treatment of cryptococcosis in non-HIV immunocompromised patients. *Curr Opin Infect Dis* 2018; PMID 29738314.
186. Chastain DB, Sam JI, Steele GM, Lowder LO, **Franco-Paredes C**. Expanding Spectrum of *Toxoplasmosis gondii*: Thymoma and Toxoplasmic encephalitis. *Open Forum Infect Dis* 2018; Jul 7;5(7):ofy163. doi: 10.1093/ofid/ofy163. eCollection 2018 Jul..
187. Bruner KT, Chastain DB, Henao-Martinez AF, **Franco-Paredes C**. *Cryptococcus gattii* complex infections in HIV-infected patients, Southeastern United States. *Emerg Infect Dis* 2018; 24(11): 1998-2002.
189. José A. Suárez, Lolimar Carreño, Alberto E. Paniz-Mondolfi, Francisco J. Marco-Canosa, Héctor Freilij, Jorge A. Riera, Alejandro Risquez, Andrea G. Rodriguez-Morales, Evimar Hernández-Rincón, Jorge Alvarado-Socarras, Gustavo Contreras, Maritza Cabrera, Rosa M. Navas, Fredi Díaz-Quijano, Tamara Rosales, Rosa A. Barbella-Aponte, Wilmer E. Villamil-Gómez, Marietta Díaz, Yenddy Carrero, Anishmenia Pineda, Nereida Valero-Cedeño, Cesar Cuadra-Sánchez, Yohama Caraballo-Arias, Belkis J. Menoni-Blanco, Giovanni Provenza, Jesús E. Robles, María Triolo-Mieses, Eduardo Savio-Larriera, Sergio

Cimerman, Ricardo J. Bello, **Carlos Franco-Paredes**, Juliana Buitrago, Marlen Martinez-Gutierrez, Julio Maquera-Afaray, Marco A. Solarte-Portilla, Sebastián Hernández-Botero, Krisell Contreras, Jaime A. Cardona-Ospina, D. Katterine Bonilla-Aldana, Alfonso J. Rodriguez-Morales. Infectious Diseases, Social, Economic and Political Crises, Anthropogenic Disasters and Beyond: Venezuela 2019-Implications for public health and travel medicine. *Rev Panam Enf Inf* 2018; 1(2):73-93.

190. Gharamati A, Rao A, Pecen PE, Henao-Martinez AF, **Franco-Paredes C**, Montoya JG. Acute Disseminated Toxoplasmosis with Encephalitis. *Open Forum Infect* Dis 2018; Oct 17; 5 (11):ofy259. doi: 10.1093/ofid/ofy259.

191. Franco-Paredes C, Rodriguez-Morales AJ, Luis A. Marcos, Henao-Martinez AF, Villamil-Gomez WE, Gotuzzo E, Bonifaz A. Cutaneous Mycobacterial Diseases. *Clin Microb Rev* 2018; 14; 32(1). pii: e00069-18. doi: 10.1128/CMR.00069-18.

192. Henao-Martínes AF, Pinto N, Henao San Martin V, **Franco-Paredes C**, Gharamati A. Successful Treatment of Gonococcal Osteomyelitis with One Week of Intravenous Antibiotic Therapy. *Int J STDs HIV* 2019;

193. Reno E, Foster G, **Franco-Paredes C**, Henao-Martinez AF. Fatal fulminant hepatitis A in a US traveler returning from Peru. *J Trav Med* 2019.

194. Canfield G, C, Mann S, Zimmer S, Franco-Paredes C. A 31-Year-Old Micronesian Man with Shoulder Fungating Mass. *Clin Infect Dis* 2019;

195. Parra-Henao G, Oliveros H, Hotez PJ, Motoa G, **Franco-Paredes C**, Henao-Martínez AF. In Search of Congenital Chagas Disease in the Sierra Nevada de Santa Marta, Colombia. *Am J Trop Med Hyg*. 2019;101(3):482-483. doi: 10.4269/ajtmh.19-0110. PMID: 31264558.

196. Bonilla-Aldana DK, Suárez JA, **Franco-Paredes C**, Vilcarromero S, Mattar S, Gómez-Marín JE, Villamil-Gómez WE, Ruíz-Sáenz J, Cardona-Ospina JA, Idarraga-Bedoya SE, García-Bustos JJ, Jimenez-Posada EV, Rodríguez-Morales AJ. Brazil burning! What is the potential impact of the Amazon wildfires on vector-borne and zoonotic emerging diseases? - A statement from an international experts meeting. *Travel Med Infect Dis*. 2019:101474. doi: 10.1016/j.tmaid.2019.101474.

197. Henao-Martinez AF, Archuleta S, Vargas D, **Franco-Paredes C**. A Latin American patient with a left ventricular pseudoaneurysm presenting with progressive dyspnea and palpitations. *Am J Med* 2019; doi: 10.1016/j.amjmed.2019.10.006

198. Canfield GS, Henao-Martinez AF, **Franco-Paredes C**, Zhelnin K, Wyles D, Gardner EM. Corticosteroids for post-transplant Immune reconstitution syndrome in *Cryptococcus gattii* Meningoencephalitis: Case report and literature review. *Open Forum Infect Dis* 2019; 6(11): ofz460. Doi: 10.1093/ofid/ofz460. PMID: 31737740.

199. Kon S, Hawkins K, **Franco-Paredes C**. Intramedullary Spinal Cord Lesions in an Immunocompromised Host due to *Mycobacterium Haemophilum*. *ID Cases* 2019;

200. Franco-Paredes C, Rodriguez-Morales AJ, Henao-Rodriguez AJ, Carrasco P, Santos-Preciado JI. Vaccination Strategies to prevent paralytic poliomielitis due to cVDPV2. *Lancet Infect Dis* 2019;

201. Motoa G, Pate A, **Franco-Paredes C**, Chastain D, Henao-Martinez Aj, Hojat L. Use of procalcitonin to guide discontinuation of antimicrobial therapy in patients with persistent intra-abdominal collections: A case series. *Case Rep Infect Dis* 2019;
202. Murillo-Garcia D, Galindo J, Pinto N, Motoa G Benamu E, **Franco-Paredes C**, Chastain D, Henao-Martinez AF. Anaerobic bacteremias in left ventricular assist devices and advanced heart failure. *Case Rep Infect Dis* 2019;
204. **Franco-Paredes, C**, Villamil-Gómez Wilmer E., Schultz, J, Henao-Martínez AF, Parra-Henao, G, Rassi Jr. A, Rodriguez-Morales AJ, Suarez JA. A Deadly Feast: Elucidating the Burden of Orally Acquired Acute Chagas Disease in Latin America - Public Health and Travel Medicine Importance. *Trav Med Infect Dis* 2020;
205. Reno E, Quan N, **Franco-Paredes C**, Chastain DB, Chauhan L, Rodriguez-Morales AJ, Henao-Martinez A. Prevention of Yellow Fever in Travelers: An Update. *Lancet Infect Dis* 2020;
206. Franco-Paredes C, Griselda Montes de Oca Sanchez, Cassandra White. Global Leprosy Status 2020: Still Losing Touch. *Ann Acad Med Singapore* 2020;
207. Rodriguez-Morales AJ, Gallego V, Escalera-Antezana JP, Mendez CA, Zambrano LI, **Franco-Paredes C**, Suarez JA, Rodriguez-Enciso HD, Balbin-Ramon GH, Savio-Larriera E, Risquez A, Cimerman S. COVID-19 in Latin America: The implications of the first confirmed case in Brazil. *Travel Med Infect Dis* 2020; doi: 10.1016/j.tmaid.2020.101613.
208. Rodríguez-Morales AJ, Cardona-Ospina JA, Gutiérrez-Ocampo E, Villamizar-Peña R, Holguin-Rivera Y, Escalera-Antezana JP, Alvarado-Arnez LE, Bonilla-Aldana DK, **Franco-Paredes C**, Henao-Martinez AF, Paniz-Mondolfi A, Lagos-Grisales GJ, Ramírez-Vallejo E, Suárez JA, Zambrano LI, Villamil-Gómez WE, Balbin-Ramon GJ, Rabaan AA, Harapan H, Dhama K, Nishiura H, Kataoka H, Ahmad T, Sah R, On behalf of the Latin American Network of Coronavirus Disease 2019-COVID-19 Research (LANCOVID-19) (www.lancovid.org). Clinical, Laboratory and Imaging Features of COVID-19: A systematic review and meta-analysis. *Travel Med Infect Dis* 2020;
209. Meyer J, **Franco-Paredes C**, Yaizal F, Gartland M, Parmar P. COVID-19 and the Coming Plague in U.S. Immigration Detention Centers. *Lancet Infect Dis* 2020;
210. Basco SA, Steele GM, Henao-Martinez AF, **Franco-Paredes C**, Chastain DB. Unexpected etiology of a pleural empyema in a patient with chronic lymphocytic leukemia (CLLL): *Capnocytophaga ochracea*. *ID Cases* 2020: Mar 20;20:e00747. doi: 10.1016/j.idcr.2020.e00747. eCollection 2020.
211. Franco-Paredes C. Albert Camus' 'The COVID-19 Plague" Revisited. *Clin Infect Dis* 2020 Apr 17. pii: ciaa454. doi: 10.1093/cid/ciaa454.PMID: 32301966.
212. Pritchett MA, Oberg CL, Belanger A, De Cardenas J, Cheng G, Cumbo Nacheli G, **Franco-Paredes C**, Singh J, Toth J, Zgoda M, Folch E. Society for Advanced Bronchoscopy Consensus Statement and Guidelines for bronchoscopy and airway management aid the COVID-19 pandemic. *J Thorac Dis* 2020 | http://dx.doi.org/10.21037/jtd.2020.04.32.
213. Reno E, Quan NG, **Franco-Paredes C**, Chastain DB, Chauhan L, Rodriguez-Morales AJ, Henao-Martínez AF. Prevention of yellow fever in travellers: an update. *Lancet Infect Dis*. 2020 May 7. pii: S1473-3099(20)30170-5. doi: 10.1016/S1473-3099(20)30170-5. PMID: 32386609.

214. Mann S, Phupitakphol T, Davis B, Newman S, Suarez JA, Henao-Martínez A, **Franco-Paredes C**. Cutaneous Leishmaniasis due to *Leishmania (Viannia) panamensis* in Two Travelers Successfully Treated with Miltefosine. *Am J Trop Med Hyg*. 2020 Apr 20. doi: 10.4269/ajtmh.20-0086. [Epub ahead of print]. PMID: 32314693.

215. Meyer JP, **Franco-Paredes C**, Parmar P, Yasin F, Gartland M. COVID-19 and the coming epidemic in US immigration detention centres. *Lancet Infect Dis*. 2020 Apr 15. pii: S1473-3099(20)30295-4. doi: 10.1016/S1473-3099(20)30295-4. [Epub ahead of print] No abstract available.PMID: 32304631.

217. Franco-Paredes C. Albert Camus' 'The COVID-19 Plague' Revisited. *Clin Infect Dis*. 2020 Apr 17. pii: ciaa454. doi: 10.1093/cid/ciaa454. [Epub ahead of print] No abstract available. PMID: 32301966.

217. Solis J, **Franco-Paredes C**, Henao-Martínez AF, Krsak M, Zimmer SM. Structural Vulnerability in the United States Revealed in Three Waves of Novel Coronavirus Disease (COVID-19). *Am J Trop Med Hyg.* 2020 May 7. doi: 10.4269/ajtmh.20-0391. PMID: 32383432.

218. Krsak M, Henao-Martinez AF, **Franco-Paredes C.** Broader COVID-19 Testing in Correctional Facilities. *N Engl J Med* 2020;

219. Canfield G, Schultz J, Windham S, Scherger S, Henao-Martinez AF, **Franco-Paredes C**, Shapiro L, Chastain D, Wand T, Krsak M. Empiric Therapies during the COVID-2019 Pandemic: Destined to Fail by Ignoring the Lessons of History. *J Hosp Med* 2020;

220. Jankousky K, Henao-Martinez AF, **Franco-Paredes C**, Shapiro L. Preventing SARS-CoV-2 Infection by Blockage of tissue serine proteases. *Ther Adv Infectious Dis* 2020;

221. Bonfiglio J, Rosal K, **Franco-Paredes C**, Poeschla E, Henao-Martinez AJ, Dunlevy H, Haas M, Moo-Young J, Seefeldt T, Young J. The Long Journey inside Immigration Detention Centers in the U.S. *J Travel Med* 2020;

222. Franco-Paredes C, Henao-Martinez AJ, Rodriguez-Morales AJ, Chauhan L, Khan MI. Current challenges to achieving a polio free world. *Ann Acad Med Singapore* 2020;

BOOK CHAPTERS:

Franco-Paredes C, Albrecht H. Anisakiasis (2007). In: Antimicrobial Therapy and Vaccines; Volume I: Microbes (www.antimicrobe.org), Yu VL, et al. (Ed). ESun Technologies, Pittsburgh, PA. 2007.

Franco-Paredes C, Albrecht H. Visceral Larva Migrans (2007). In: Antimicrobial Therapy and Vaccines; Volume I: Microbes (www.antimicrobe.org), Yu VL, et al. (Ed). ESun Technologies, Pittsburgh, PA. 2007.

Franco-Paredes C. American Trypanosomiasis. Chagas'Disease. In: Eds: Kozarsky P, Arguin P, Reed C. Yellow Book: Health Information for Travelers 2007-2008, Centers for Disease Control and Prevention, Elsevier Ltd.

Franco-Paredes C. The Post-travel Period. In: Eds: Kozarsky P, Arguin P, Reed C. Yellow Book: Health Information for Travelers 2007-2008, Centers for Disease Control and Prevention, Elsevier Ltd.

Hidron A, **Franco-Paredes C**. American Trypanosomiasis. Chagas'Disease. In: Eds: Brunnete GW, Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2009-2010, Centers for Disease Control and Prevention, Elsevier Ltd, 2009. ISBN: 978-0-7020-3481-7.

Franco-Paredes C. General Approach to the Returned Traveler. In: Eds: Brunnete GW, Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2009-2010, Centers for Disease Control and Prevention, Elsevier Ltd, 2009. ISBN: 978-0-7020-3481-7.
Franco-Paredes C. Asymptomatic Screening of the Returned Traveler. In: Eds: Brunnete GW, Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2009-2010, Centers for Disease Control and Prevention, Elsevier Ltd, 2009. ISBN: 978-0-7020-3481-7.
Franco-Paredes C, Santos-Preciado JI. Introduction of Antimicrobial Agents in Poor-Resource Countries: Impact on the Emergence of Resistance. In: Antimicrobial Resistance in Developing Countries. Ed. Byarugaba DK, Sosa A. Springer Science & Business Media, 2010.
Hidron A, **Franco-Paredes C**. American Trypanosomiasis. Chagas'Disease. In: Eds: Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2011-2012. Centers for Disease Control and Prevention, Elsevier Ltd, 2011. ISBN: 978-0-7020-3481-7.
Franco-Paredes C, Hochberg N. General Approach to the Returned Traveler. In: Eds: Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2011-2012, Centers for Disease Control and Prevention, Elsevier Ltd, 2011. ISBN: 978-0-7020-3481-7.
Franco-Paredes C. Asymptomatic Screening of the Returned Traveler. In: Eds: Kozarksy P, Magill A, Shlim D. Yellow Book: Health Information for Travelers 2011-2012, Centers for Disease Control and Prevention, Elsevier Ltd, 2009. ISBN: 978-0-7020-3481-7.
Hochberg N, **Franco-Paredes C**. Emerging Infections in Mobile Populations. In: Emerging Infections 9. Ed. Scheld WM, Grayson ML, Hughes JM. American Society of Microbiology Press 2010. ISBN. 978-1-55581-525-7.
Franco-Paredes C, Chagas Disease (American Trypanosomiasis). In: Farrar J, Hotez P, Junghanss T, Kang G, Lalloo D, White NJ. Manson's Tropical Medicine 23rd Edition, Elsevier, London, U.K., 2014.
Franco-Paredes C, Keystone J. Fever in the Returned Traveler**.** In: Empiric, Antimicrobial Therapy and Vaccines (www.antimicrobe.org). Yu VL, et al (Ed). ESun Technologies, Pittsburgh, PA, 2014.
Franco-Paredes C. *Mycobacterium leprae* (Leprosy). In: Antimicrobial Therapy and Vaccines (www.antimicrobe.org). Yu VL, et al (Ed). ESun Technologies, Pittsburgh, PA, 2015
Franco-Paredes C, Albrecht H. Anisikasis In: Antimicrobial Therapy and Vaccines (www.antimicrobe.org). Yu VL, et al (Ed). ESun Technologies, Pittsburgh, PA, 2015.
Franco-Paredes C. Illness and Death in the Universe. In: Narrative Medicine Anthology. Ed: Tom Janisse. The Permanente Press, Oakland, California, Portland Oregon, 2016, pp. 23-25. ISBN: 978-0-9770463-4-8.
Villamil-Gomez W, Reyes-Escalante M, **Franco-Paredes C.** Severe and complicated malaria due to *Plasmodium vivax*. In: Current Topics in Malaria. Ed: Rodriguez-Morales AJ. ISBN 978-953-51-2790-1, Print ISBN 978-953-51-2789-5. InTechOpen 2016.
Franco-Paredes C. Mycobacterial Infections of the Central Nervous System. In: The Microbiology of the Central Nervous System Infections. Ed. Kon K, Rai M. Elsevier 2018. ISBN 978-0-12-813806-9
Franco-Paredes C. Leprosy. In: Neglected Tropical Diseases. Drug Discovery and Development. Ed: Swinney D, Pollastri. Wiley-VCH Verlag GmbH & Co. KGaA, 2019.
Franco-Paredes C, Henao-Martinez AJ. Legal Perspectives in Travel Medicine. In: Eds: Kozarksy P, Weinberg M. Yellow Book: Health Information for Travelers 2019-2020, Centers for Disease Control and Prevention, Elsevier Ltd, 2011. ISBN: 978-0-7020-3481-7.
Franco-Paredes C. Prevención de la transmisión. **In:** Guerrero MI, Hernández CA y Rodríguez G Editores La lepra: una enfermedad vigente. Centro Dermatológico Federico Lleras Acosta Bogotá DC, Colombia. Panamericana Formas e Impresos. 2019. **p. 309-322.**

Published Abstracts in Peer-Reviewed Journals:

Kleinschmidt-DeMasters B, Hawkins K, **Franco-Paredes C**. Non-tubercular mycobacterial spinal cord abscesses in an HIV plus male due *M. haemophilum*. J *Neuropathol Experim Neurol* 2018; 77(6): 532.

Pate A, **Franco-Paredes C**, Henao-Martinez A. Cryptococcal meningitis: A comparison of clinical features and outcomes by HIV Status. *Open Forum Infect Dis* 2019; Oct 6 (Suppl 2): S629-S630. PMC6809090.

FORMAL TEACHING

Medical Student Teaching

2001 - 2002	Clinical Methods, Emory University School of Medicine
2001 - 2002	Clinical Instructor Harvey Cardiology Course, Emory University School of Medicine
2001 - 2002	Problem-Based Learning for Second year Medical Students, EUSM
2005-2011	Clinical Methods Preceptor, ECLH
2006-2008	Medical Spanish - Instructor for M2, EUSM
2006-2007	Directed Study on Social Determinants of Infectious Diseases for M2 students (Lindsay Margolis and Jean Bendik), EUSM
2007-2011	Instructor - Global Health for M2 Students, EUSM
2007-2008	Presentation-Case Discussion – Social Determinants of Diseases – Coordinated by Dr. Bill Eley – Emory School of Medicine New Curriculum.
2018-	Small Group: Parasitic Diseases, Microbiology Course for First Year Medical Students, University of Colorado, Anschutz Medical Center.
2019-	MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite
2019-	Class Global Health and Underserved Populations of the New SOM CU Curriculum. Course Co-Director. Pilot Class (Jan 6-Jan 17, 2020).
2020-	MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite

Graduate Program

Training programs

2006-2011	Professor - GH511 (Global Health 511) International Infectious Diseases Prevention and Control, Rollins School of Public Health
2009-2011	Professor – GH500 D – Key Issues in Global Health, Career MPH Program
2006-2011	Thesis Advisor to students Global Health Track – Hubert Department of Global Health, Rollins School of Public Health of Emory University
2008-2011	Coordinator International Exchange between Rollins School of Public Health and National Institute of Public Health, Cuernavaca, Mexico – Supported by the Global Health Institute of Emory University

Residency and Fellowship Program:

2004-2011	Resident Report – Noon Conferences Emory Crawford Long Hospital and Grady Memorial Hospital
2004-2011	Didactic Lectures on Parasitic Diseases and Non-tuberculous mycobacterial diseases for Internal Medicine Residents and Infectious Disease Fellows
2005-2008	Coordinator Journal Club Infectious Disease Division
2005-2011	Travel Medicine Elective, Internal Medicine Residents (2 internal residents per month)

2005	Grand Rounds – EUH - Department of Medicine: "Travel Medicine"
2006	Grand Rounds – ECLH – Department of Medicine: "Malaria"
2008	Grand Rounds - ECLH – Department of Medicine: "Leprosy"
2008-2011	Journal Club Coordinator, Internal Medicine Residency Program – ECLH
2009	Grand Rounds - EUH – Department of Medicine: "Leprosy a Modern Perspective of an Ancient Disease"
2009	Grand Rounds – Pulmonary and Critical Care Division – Neglected Tropical Diseases of the Respiratory Tract, June 16, 2009
2017	Grand Rounds – Leprosy, University of Colorado, Anschutz Medical Center, Division of Infectious Diseases, December 2017
2017	Grand Rounds – Infections associated with Secondary Antiphospholid Syndrome, University of Colorado, Anschutz Medical Center, Division of Rheumatology,
2018	Didactic Session – Travel Medicine (Pretravel and Postravel) Infectious Diseases Fellowship Anschutz Medical Center, Division of Infectious Diseases
2017-	Infectious Diseases Fellows Clinic, University of Colorado, Anschutz Medical Center, IDPG.
2019	Invited Speaker: Travel Medicine, Pretravel/Postravel Care, Physician Assistant Program, September 12, 2019, University of Colorado, Anschutz Medical Center

Other categories:

2000-2002	Physician Assistant Supervision during Fellowship/Junior Faculty, Emory University
2004-2007	Mentoring of four College Students to enter into Medical School (Emory, Southern University, and Dartmouth): Lindsay Margolis 2004-Emory University Michael Woodworth 2005 – Emory University Peter Manyang 2007 – Southern University Padraic Chisholm 2007 – Southern University/Emory University
2009-2011	Project Leader. Partnership – Emory Global Health Institute – University-wide - Emory Travel Well Clinic and is titled Hansen's disease in the state of Georgia: A Modern Reassessment of an Ancient Disease". http://www.globalhealth.emory.edu/fundingOpportunities/projectideas.php. Students: 5 MPH students (RN/MPH, MD/MPH)
2017-	Infectious Diseases Fellowship Program, University of Colorado, Anschutz Medical Center. Teaching activities Inpatient and outpatient (ID Fellows Weekly Clinic)
2019-	Infectious Diseases Fellowship Program Director University of Colorado, Aurora Colorado

Supervisory Teaching:

Ph.D. students directly supervised:

Global Health, Rollins School of Public Health - PhD Task Force Member – 2007-2009

Residency Program:

Emory University: Internal Medicine Residents and Infectious Disease Fellows Supervision – Inpatient Months – 3-4 months per year on Grady Wards. I participated in the presentation and discussion of clinical cases, and discussion of peer-reviewed journal with medical students, residents, and fellows. Overall evaluations: Outstanding Teacher. (Anna Von 2005-2006; Seth Cohen 2008, Susana Castrejon

2007; Lindsay Margoles 2007-2008; Jean Bendik 2006-2008; Meredith Holtz 2007-2008)
University of Colorado, Anschutz Medical Center (since June 2017- present). Case discussion in infectious diseases during clinical rounds inpatient services (ID Gold, ID Blue, ID Orthopedics).
2004-2009 Thesis advisor – MPH Students – Hubert Department of Global Health – Concentration Infectious Diseases: Brenda Thompson 2004; Katrina Hancy 2004; Trina Smith 2006; Melissa Furtado 2007-2008; Oidda Museru 2008-2009; Hema Datwani 2010; Ruth Moro 2010; Talia Quandelacy 2010
2015 – Class GH511, Topic: "Leprosy" as part of the International Infectious Diseases, Global Health Track, Rollins Schoolf of Public Health, Emory University, Atlanta GA
2017 – Class GH511, Topic: "Leprosy" as part of the International Infectious Diseases, Global Health Track, Rollins School of Public Health, Emory University, Atlanta GA
2019 - Project Mentorship – Diffuse lepromatous leprosy. Undergraduate Student, University of Colorado, Boulder. Mikali Ogbasselassie. Project was carried out in Collaboration with the Dermatology Center of the Hospital General de Mexico.
Poster presentation by Mikali Ogbasselassie September 22, 2019, UMBC, Baltimore, Maryland.

Activities during the COVID-19 Pandemic targeting protecting vulnerable groups living in the US including outbreaks of COVID-19 in Jails/Prisons/ICE Detention centers/community reengagement facilities (i.e. hallway houses)

<u>In-person inspections in facilities with outbreaks of COVID-19 in collaboration with civil rights attorneys from ACLU and Civil Right Corps. Goal to improve conditions in jails and prisons and to promote decarcelation</u>
Jail Inspection Weld County Jail April 10, 2020
Jail Inspection Weld County Jail April 24, 2020
Jail Inspection Oakland County, Jail, Pontiac Michigan April 23, 2020

<u>In-person inspections in facilities with COVID-19 outbreaks –court appointed</u>
Jail Inspection Prince George's County Jail, Maryland, May 6, 2020 (Court Appointed, Federal Judge, Paola Xinis, Maryland)
Jail Inspection Prince George's County Jail, Maryland, May 7, 2020 (Court Appointed, Federal Judge, Paola Xinis, Maryland)

<u>Declarations- Affidavits</u>
L.A. County Jail
West Metro Detention Center, Florida
Florence, Arizona, Prison, Arizona

<u>Advocacy Letters:</u>

Carlos Franco-Paredes, MD, MPH

1. Dean Williams – Executive Director of the Colorado Department of Corrections, Governor Jared Polis and correctional leaders. https://acluco-wpengine.netdna-ssl.com/wp-content/uploads/2020/03/COVID-19-Letter-C-Franco-Paredes-MD.pdf
   I have kept in direct communication with Mr. Williams to provide recommendations regarding release of prisoners, testing strategies, and population management at Sterling Prison in Colorado.

2. Letter to CDC. https://www.drugpolicy.org/sites/default/files/cdc-letter-decarceration_0.pdf

3. Letter New Jersey Senator Melendez to Department of Homeland Security
   https://www.menendez.senate.gov/download/letter-dhs-ice-release-vulnerable-detainees-covid19

Other Publications:

Articles in Magazines and Newspapers COVID-19

Colorado Sun - Op-ED- COVID-19
https://coloradosun.com/2020/03/29/colorado-immigrant-detention-coronavirus-geo-opinion/Westword

Westword
https://www.westword.com/news/petition-asks-supreme-court-to-help-lower-colorado-jail-population-11680821

Reuters
https://www.reuters.com/article/us-health-coronavirus-usa-detention-insi/as-pandemic-rages-u-s-immigrants-detained-in-areas-with-few-hospitals-idUSKBN21L1E4

Mother Jones
https://www.motherjones.com/politics/2020/03/ice-is-ignoring-recommendations-to-release-immigrant-detainees-to-slow-the-spread-of-coronavirus/

Expansion
https://expansion.mx/mundo/2020/04/06/centros-de-detencion-de-migrantes-en-eu-una-bomba-de-tiempo-ante-la-pandemia.

Mother Jones
https://www.motherjones.com/politics/2020/04/a-doctor-on-ices-response-to-the-pandemic-you-could-call-it-covid-19-torture/

ACLU Colorado
https://aclu-co.org/doingmypartco/
Westword
https://www.westword.com/news/petition-asks-supreme-court-to-help-lower-colorado-jail-population-

Carlos Franco-Paredes, MD, MPH

11680821

Theappeal.org
https://theappeal.org/colorado-supreme-court-fails-to-protect-state-residents-as-coronavirus-grows-exponentially-in-jail/

The Gazette
https://gazette.com/opinion/guest-column-how-covid-19-underscores-the-consequences-of-mass-incarceration/article_d5f389ce-80c1-11ea-a978-9f1fe73dc0a2.html.

The Daily Tribune
https://www.dailytribune.com/news/coronavirus/federal-judge-to-consider-dismissing-lawsuit-more-changes-at-oakland-county-jail-due-to-covid/article_34314ff1-9620-5a90-a546-f2f4c0f92a4f.html

COVID-19 parole informational guide for sponsors
https://pennstatelaw.psu.edu/sites/default/files/IJP_SIFI%20COVID-19%20Pro%20Se%20Parole%20Request%20Information%20Packet%20ENG%20MAR%202020-final%20web.pdf

Letter New Jersey Senator Melendez to Department of Homeland Security
https://www.menendez.senate.gov/download/letter-dhs-ice-release-vulnerable-detainees-covid19

The Washington Post
https://www.washingtonpost.com/local/public-safety/federal-judge-orders-inspection-of-pr-georges-jail-after-inmates-worried-about-coronavirus-sue/2020/05/01/349436fe-8bc1-11ea-9dfd-990f9dcc71fc_story.html

MichiganRadio NPR
https://www.michiganradio.org/post/i-fear-i-may-die-here-inmates-oakland-county-jail-plead-help-lawsuit

The Crime Report
https://thecrimereport.org/2020/04/23/is-dysfunctional-migrant-health-care-fueling-infections/

Witness L.A.
https://witnessla.com/searing-new-law-suit-describes-la-county-jail-conditions-that-are-an-incubator-for-death/

Detroit Free Press
https://www.freep.com/story/news/local/michigan/2020/05/05/wayne-county-jail-coronavirus-lawsuit-medically-vulnerable-inmates/3076656001/

The Washington Post
https://www.washingtonpost.com/local/public-safety/prince-georges-jail-must-plan-to-test-more-inmates-for-covid-19-federal-judge-orders/2020/05/11/b989a420-93b4-11ea-9f5e-

Carlos Franco-Paredes, MD, MPH

56d8239bf9ad_story.html

Denver Post
https://www.denverpost.com/2020/05/15/coronavirus-covid-testing-colorado-jails/

Accounts and Legal Proceedings of individuals Released from Jails, Prisons, and Immigration Detention Centers (Releases, Temporary Restriction Orders, and Preliminary Injunctions

1. Faour Abdallah Fraihat, et al. V. U.S. Immigration and Customs Enforcement grant Motion for preliminary injunction and class certification by the United States District Court of California
2. El Paso, Texas. Immigration Detention Center
3. Thomas O'Meara – Release of 4 Detainees from Taylor, Texas Detention Center
4. New York, Basanak vs. Thomas Decker. Temporary Restriction Order/Preliminary Injunction.
5. Daniel Williams, ACLU, Colorado. Thomas Carranza et al vs. Steven Reams. Temporary Restriction Order by Judge Phillip J. Brimmer, United States District of Colorado