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16 **UNITED STATES DISTRICT COURT**
17 **CENTRAL DISTRICT OF CALIFORNIA**
18 **EASTERN DIVISION – RIVERSIDE**

19 FAOUR ABDALLAH FRAIHAT, *et al.*,
20 Plaintiffs,

21 v.

22 U.S. IMMIGRATION AND CUSTOMS
23 ENFORCEMENT, *et al.*,

24 Defendants.
25
26
27
28

Case No.: 19-cv-01546-JGB(SHKx)

**Plaintiffs' Notice of Motion and
Motion to Enforce the April 20, 2020
Preliminary Injunction Order**

Hearing Date: July 13, 2020

Time: 2:00 pm

Hon. Jesus G. Bernal

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**Pro Hac Vice Application Forthcoming

NOTICE OF MOTION AND MOTION TO ENFORCE THE
APRIL 20, 2020 PRELIMINARY INJUNCTION ORDER

TO THE HONORABLE COURT, ALL PARTIES, AND THEIR
 ATTORNEYS OF RECORD HEREIN:

NOTICE IS HEREBY GIVEN that on July 13, 2020 at 2:00 PM or at such
 other time as the Court may set the matter for hearing, Plaintiffs Faour Fraihat,
 Jimmy Sudney, Aristoteles Sanchez Martinez, Alex Hernandez, and Martin Munoz
 on behalf of themselves and all others similarly situated, will and hereby do move
 for an order granting a motion to enforce the April 20, 2020 preliminary injunction
 order¹ and granting all such relief as set forth in the Proposed Order.

This Motion is based on this Notice of Motion, the accompanying
 Opening Brief, the supporting declarations, proposed order, all pleadings, and
 papers filed in this action, and such additional papers and arguments as may be
 presented at or in connection with the hearing.

DATED: June 24, 2020 Respectfully submitted,

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 Shalini Goel Agarwal
 Maia Fleischman
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/s/ Timothy P. Fox
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¹ Pursuant to Local Rule 7-3, Plaintiffs met and conferred with Defendants on the
 subject of the motion on June 12, 2020. See Declaration of Timothy P. Fox In
 Support of Plaintiffs' Motion To Enforce The April 20, 2020 Preliminary
 Injunction Order.

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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**Plaintiffs' Opening Brief in Support
of Motion to Enforce the April 20,
2020 Preliminary Injunction Order**

Hearing Date: July 13, 2020

Time: 2:00 pm

Hon. Jesus G. Bernal

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1 **I. Introduction**

2 Six weeks ago, the Court had “little difficulty finding Defendants are not
3 complying with multiple aspects of the Preliminary Injunction,” referencing the
4 Preliminary Injunction Order (“PI Order”) (ECF 132) it had issued less than a
5 month earlier (ECF 150, the “May 15 Order,” at 6). Various describing
6 Defendants’ response to the PI Order as “lethargic,” a “slow walk,” “cavalier” and
7 “lackadaisical” (*id.* at 5-6), the Court directed Defendants to rapidly provide
8 specified information to Plaintiffs’ counsel that would permit them to monitor, and
9 the Court to enforce, compliance with the PI Order.

10 Now, 40 days after the May 15 Order and 65 days after the PI Order, it is
11 painfully evident that Defendants are not complying with the Court’s orders. In
12 direct contravention of this Court’s command to “promptly” revise the PRR,
13 Defendants failed to do so until June 22 in apparent anticipation of this motion.
14 Defendants have again deployed the “ambush” strategy decried by the Court (ECF
15 150 at 4). In any event, those revisions are still woefully deficient and fail to
16 provide necessary precautions to protect people with Risk Factors. In addition,
17 Defendants continue to refuse to implement meaningful oversight measures and to
18 conduct good faith custody re-determinations. In the meantime, the COVID-19
19 crisis continues to escalate, ever-more-acutely the subclass with serious illness and
20 death. Accordingly, Plaintiffs respectfully ask the Court to exercise its “inherent
21 authority to monitor and enforce” its prior orders (*id.*) by entering the proposed
22 enforcement order for the reasons discussed below.

23 **II. Background**

24 At the time the Court issued the PI Order on April 20, ICE had reported 124
25 confirmed COVID-19 cases among the immigrant population it detained
26 nationwide (Fox Decl. ¶ 18 & Ex. 13). By the time the Court entered the May 15
27 Order less than a month later, the number of confirmed cases had ballooned nearly
28 eight-fold to 986. *Id.* Now the number has reached a staggering total of 2,489 (*id.*).

1 This month alone, massive increases at individual facilities vividly confirm the
2 scope of the crisis and the inadequacy of Defendants' response; *e.g.*, the June
3 numbers have risen from 132 to 252 at Bluebonnet, from 1 to 208 at Eloy, from 22
4 to 133 at Montgomery, from 44 to 117 at El Paso, from 2 to 64 at Glades, and from
5 3 to 61 at Port Isabel. *Id.*

6 The PI Order directed Defendants to:

- 7 • Provide ICE Field Office Directors with the Risk Factors identified in
8 the Subclass definition;
- 9 • Identify and track all ICE detainees with Risk Factors;
- 10 • Make timely custody determinations for detainees with Risk Factors;
- 11 • Provide necessary training to any staff tasked with identifying
12 detainees with Risk Factors, or delegate that task to trained medical
13 personnel;
- 14 • Provide the above relief to all detainees with Risk Factors, regardless
15 of whether they have submitted requests for bond or parole, have
16 petitioned for habeas relief, have requested other relief, or have had
17 such requests denied;
- 18 • Promptly issue a performance standard or supplement to their
19 Pandemic Response Requirements ("PRR") defining the minimum
20 acceptable detention conditions for detainees with Risk Factors,
21 regardless of the statutory authority for their detention, to reduce their
22 risk of COVID-19 infection pending individualized determinations or
23 the end of the pandemic; and
- 24 • Monitor and enforce facility-wide compliance with the PRR and
25 Performance Standard.

26 While Defendants purport to have complied with some of these
27 requirements, they have entirely failed to comply with others. Defendants waited
28 more than two months after the PI Order to revise their PRR and, as explained

below, those revisions fail to provide comprehensive, medically necessary precautions to protect people with Risk Factors from harm. Defendants have also violated the PI Order's requirement that they monitor and enforce facility-wide compliance with the PRR, instead relying on pre-existing broken oversight mechanisms. Defendants have also failed to timely and meaningfully conduct the custody determinations required by the PI, refusing to release the vast majority of people with Risk Factors, often issuing *pro forma* denials without explanation, and arbitrarily denying release to all people in mandatory detention in violation of the PI Order's requirement that they make individualized custody determination for all people with Risk Factors "regardless of the statutory authority for their detention."

Defendants' widespread failures to fully comply with the PI Order require strong enforcement measures from the Court to ensure immediate compliance and protect the subclass members at critical risk in ICE's custody. And, given that Defendants have continued to "slow walk" their compliance for another six weeks after the Court called them to task for that behavior (ECF 150 at 5), Plaintiffs respectfully request that this Court appoint a Special Master to monitor Defendants' future compliance and provide real-time reports that will inform the Court's efforts to protect all subclass members from grave harm.

III. Legal Standard

As the Court has noted earlier in these proceedings, "[c]ourts have inherent authority to monitor and enforce their prior orders. ECF 150 at 4 (citing *Shillitani v. United States*, 384 U.S. 364, 370 (1966)). When it becomes clear that defendants continue to engage in conduct contrary to an injunction, the party who sought the injunction may move the court to issue an order mandating compliance. *Armstrong v. Brown*, 857 F. Supp. 2d 919, 951 (N.D. Cal. 2012); *Salazar v. Buono*, 559 U.S. 700, 712 (2010) ("A party that obtains a judgment in its favor acquires a 'judicially cognizable' interest in ensuring compliance with that judgment."). And if the court determines a violation is occurring, the court has broad discretion to grant the relief

1 necessary to prevent the infringement of its injunction. *Id.* at 712-13.

2 The Court also has authority to modify its injunction, which is appropriate
3 where there has been “a significant change in facts or law.” *Sharp v. Weston*, 233
4 F.3d 1166, 1170 (9th Cir. 2000). Modification is also appropriate to “achieve the
5 purposes” of the original injunction. *United States v. United Shoe Mach. Corp.*,
6 391 U.S. 244, 249 (1968). Courts have “wide discretion” to modify an injunction.
7 *System Federation No. 91 v. Wright*, 364 U.S. 642, 647 (1961); *A&M Records Inc.*
8 *v. Napster, Inc.*, 284 F.3d 1091, 1098 (9th Cir. 2002). Finally, a district court
9 retains jurisdiction to enforce and modify its injunctions during the pendency of
10 any interlocutory appeal. Fed. R. Civ. P. 62(c); *A&M Records*, 284 F.3d at 1099.

11 **IV. Defendants’ Revised PRR Continues to Permit Dangerous Practices** 12 **that Threaten People with Risk Factors**

13 The PI order explicitly required that Defendants “promptly” issue a
14 comprehensive standard “for the safe detention of at risk detainees pending
15 custody decisions, or in the event ICE deems detainees ineligible for release”
16 ECF 132 at 38. Rather than “promptly” doing so, Defendants waited over two
17 months—until they were on notice of Plaintiffs’ intent to file this motion.

18 During Defendants’ two-month delay, people with Risk Factors continued to
19 face dangerous conditions of confinement. Indeed, the exponentially increasing
20 rate of COVID-19 cases in ICE detention confirms the dire consequences of
21 Defendants’ unreasonable delays. Today, ICE has reported 2,489 confirmed
22 COVID-19 positive cases among the detained population.¹ This means that the

23 ¹ [ICE.gov/coronavirus](https://www.ice.dhs.gov/coronavirus) (updated June 24, 2020). *But see*, “[T]he true number of
24 people who have been infected in ICE detention may be 15 times higher
25 than official numbers and is still increasing.” Nina Siulc, *Vera’s new*
26 *prevalence model suggests COVID-19 is spreading through ICE detention at much*
27 *higher rates than publicized*, VERA INSTITUTE OF JUSTICE (June 4, 2020)
28 <https://www.vera.org/blog/covid-19-1/veras-new-prevalence-model-suggests-covid-19-is-spreading-through-ice-detention-at-much-higher-rates-than-publicized>;
see also Michael Irvine, *Modeling COVID-19 and impacts on U.S. Immigration and Enforcement (ICE) detention facilities*, 2020 JOURNAL OF URBAN HEALTH (in press) <https://whistleblower.org/wp->

1 number of infections has multiplied by a factor of 20 since entry of the PI order
2 when there were only 124 confirmed cases.²

3 These dangers are confirmed by DHS's own reports. An OIG report
4 addressing COVID-19 in detention facilities recently reached some startling
5 conclusions: (1) only 54% of the 157 nondedicated detention facilities had on-site
6 testing capacity, and only 20% of these facilities had actually conducted tests; (2)
7 34% of nondedicated facilities did not have any negative pressure ventilation
8 rooms, and overall, "facilities reported concerns with their inability to practice
9 social distancing . . . and to isolate or quarantine individuals who may be infected
10 with COVID-19;" and (3) "many facilities expressed concern about maintaining
11 sufficient supplies of PPE, as well as future shortages, if the pandemic continues. "
12 Fox Decl. ¶ 22 & Ex. 17 at 6, 7-8, 10, 13.

13 In addition, the attached declarations from detained people and legal service
14 providers show in harrowing detail how conditions in detention continue to pose
15 grave dangers. *See, e.g.*, Gonzalez Morales Decl.; Zwick Decl.; Doubossarskaia
16 Decl.; Vosburgh Decl.; Mencias-Soto Decl.; King Decl.; Page Decl.; Perez Aguirre
17 Decl.; Hernandez Decl.; Saenz Decl.; Rios Decl.; Corchado Decl.; Feldman Decl.;
18 Lunn Decl.; Flewelling Decl.; Schneider Decl.; Lienhard Decl.; Navarro Garcia
19 Decl.; Bailey Decl.; Edgerton Decl.; Dobbins Decl.; Russell Decl.; Rivera Decl.;
20 Pasch Decl. As detailed below and in the attached expert reports, there are
21 numerous precautionary measures that ICE should have implemented in a revised
22 PRR or standard to protect people with Risk Factors. Such measures include
23 expansion of testing, prohibitions on dangerous transfers, safe conditions for
24 medical isolation and quarantine, proper use of disinfectant, and additional medical
25 screening for people with Risk Factors, among other precautionary measures. That
26

27 [content/uploads/2020/04/Irvine_JUH_ICE_COVID19_model.pdf](#) (72% of
28 individuals in ICE custody are expected to be infected over a 90-day period).

² [ICE.gov/coronavirus](#) (updated June 24, 2020).

Defendants failed to include these necessary precautions in its delayed revisions reflects callous indifference to the risk of harm to people with Risk Factors.

A. Defendants’ Inadequate Testing Protocols Threaten the Subclass

With rare exceptions, Defendants provide COVID-19 testing only for individuals who exhibit symptoms³—a dangerous practice that threatens people with Risk Factors. As of June today, ICE has tested just over one third of the detained population, yielding a test-positivity rate of 28%. Fox Decl. Ex. 13. While ICE’s test-positivity rate is already higher than that of the United States (10%) and much higher than the target rate recommended by the World Health Organization (5%), it is likely just the tip of the iceberg.⁴ Indeed, “the overall lack of testing by ICE, combined with the fact that many people show no or few symptoms, means that the current number of infected detainees are likely just a small fraction of overall positive cases.” Venters Decl. ¶ 18.

In practice, however, even people with symptoms are not guaranteed testing. By Defendants’ own admissions, individuals who exhibit symptoms are not immediately tested but rather “considered for testing.”⁵ Defendants also only test detained individuals they transfer if they are “actively ill,” or “showing symptoms.”⁶ Such dangerous practices comport with the experiences of detained individuals across the country. See Zwick Decl. ¶¶ 21-22, 33, 38; Doubossarskaia Decl. ¶¶ 26-28; Vosburgh Decl. ¶¶ 19-21; Mencias-Soto Decl. ¶¶ 7, 14; Corchado

³ *COVID-19 IN ICE CUSTODY Biweekly Analysis & Update*, FREEDOM FOR IMMIGRANTS at 2 (June 18, 2020) <https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/5eebc846c4275f35d9c6c110/1592510535009/FFI+June+18+COVID-19+update.pdf>.

⁴ Anna Duffy, *What ICE’s Numbers Tell Us. And What They Don’t*, DETAINED IN DANGER (June 9, 2020) <http://www.detainedindanger.org/article>.

⁵ @ReynaldoLeanos, TWITTER (June 16, 2020, 4:48 PM) <https://twitter.com/ReynaldoLeanos/status/1272994502765096962?s=20>; Feldman Decl. ¶ 41 (detailing hunger strike for testing even for symptomatic people).

⁶ Monique O Madan, *ICE admits to transferring detainees with COVID-19, says it can’t test everybody*, MIAMI HERALD (May 28, 2020) <https://www.miamiherald.com/news/local/immigration/article243031176.html>.

Decl. ¶¶35; Pasch ¶20; Navarro Garcia Decl. ¶¶4-5.

Defendants' inadequate testing practices not only risk delayed diagnosis for people with Risk Factors but also heighten the probability that people with Risk Factors will be infected by un-tested asymptomatic people. The need for testing is widely understood to be necessary for mitigation efforts. This is especially true in detention centers. Universal testing, even for asymptomatic individuals, is critical to reducing infection. *See* Venters Decl. ¶ 18; Vassallo Decl. ¶ 34. That Defendants have offered voluntary COVID-19 testing in only two detention centers, a decision that came in response to litigation in one of the facilities, and still plan to evaluate testing at these locations "before expanding to the other ICE detention facilities over the next few months"⁷ exhibits callous indifference as well as a sharp contrast to actions by prisons and jails.⁸ Failure to expand testing will undoubtedly increase infection rates overall as well as for medically vulnerable people. Defendants' revisions to the PRR fail to address these deficiencies, which continue to threaten people with Risk Factors. Venters Decl. ¶ 18; Vassallo Decl. ¶ 34.

B. Defendants' Failure to Issue Revised Guidance to Limit Transfers Threatens the Subclass

Defendants have likewise failed to issue additional standards to protect medically vulnerable people from the inherent dangers of inter-facility transfers. Indeed, as detailed in the attached declarations, ICE continues to aggressively and unnecessarily transfer people without proper screening for COVID-19 in direct contravention of the CDC guidelines, which state that the transfers should be

⁷ ICE offers voluntary COVID-19 testing to all detainees at 2 facilities (June 9, 2020) <https://www.ice.gov/news/releases/ice-offers-voluntary-covid-19-testing-all-detainees-2-facilities>.

⁸ *See, e.g.,* Cary Aspinwall, *These Prisons Are Doing Mass Testing For COVID-19—And Finding Mass Infections*, THE MARSHALL PROJECT (Apr. 24, 2020) <https://www.themarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections>.

1 postponed unless “absolutely necessary.”⁹ Hundreds of immigrants are
2 continuously shuttled between different detention facilities with confirmed cases of
3 COVID-19. King Decl. ¶ 16 (reporting a group of people being transferred from
4 Florida to Georgia to Florida to Louisiana within two days); Lunn Decl. ¶ 13
5 (reporting 21 people being transferred into Aurora within the last week); Vosburgh
6 Decl. ¶ 17 (reporting 30 individuals transferred to ICE custody at Etowah within
7 the last two weeks); Page Decl. ¶ 16 (transferring detained individuals from facility
8 to the airport for deportation only to be brought back to the facility and placed in
9 the general population); Fox Decl. ¶¶ 15-16. One detained individual reports being
10 transferred a total of 18 times since mid-April. King Decl. ¶ 19.

11 During transfers, Defendants fail to provide adequate safeguards to protect
12 detained individuals from COVID-19, and detained individuals typically travel in
13 unsanitary conditions. Zwick Decl. ¶ 32 (describing transfers in which detained
14 individuals do not have PPE and are in tight spaces with people exhibiting
15 COVID-19 symptoms). When detained individuals leave from or arrive at a
16 facility, ICE does not conduct universal testing, unlike the Bureau of Prisons
17 (BOP), which tests all individuals upon arrival and before departure.¹⁰ ICE admits
18 that it does not test individuals prior to transferring them between facilities, and
19 only tests individuals presenting clear COVID-19 symptoms.¹¹ This dangerous
20 practice ignores the high rate of contagion posed by asymptomatic carriers.

21
22
23
24 ⁹ Centers for Disease Control, *Interim Guidance on Management of Coronavirus*
25 *Disease 2019 (COVID-19) in Correctional and Detention Facilities*, at 9 (Mar. 23,
26 2020) [https://www.cdc.gov/coronavirus/2019-ncov/community/correction-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
27 [detention/guidance-correctional-detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html).

28 ¹⁰ See *Hearing on Examining Best Practices for Incarceration and Detention*
During COVID-19 Before the S. Comm. Of the Judiciary, 116th Congress (2020)
(statement of Henry Lucero, Executive Associate director of Enforcement and
Removal Operations),
<https://www.judiciary.senate.gov/imo/media/doc/Lucero%20Testimony.pdf>.

¹¹ Madan, *supra* note 6.

1 ICE's unnecessary transfer of detained individuals between facilities has
2 further spread the virus, and in some instances, seemingly brought the virus to new
3 facilities.¹² For example, 16 out of 33 detained individuals tested positive for
4 COVID-19 within hours of being transferred from Krome to Broward.¹³ Similarly,
5 on June 16, 2020, the Director of Farmville Detention Center confirmed that 34
6 people who had been recently transferred to Farmville tested positive for COVID-
7 19 upon arrival. Feldman Decl. ¶¶ 27-29. For that very reason, the CDC guidelines
8 advise that "transfer should be avoided due to the potential to introduce infection to
9 another facility; proceed only if no other options are available."¹⁴

10 These ongoing transfers exponentially increase the likelihood that people
11 with Risk Factors will become infected with COVID-19. Venters Decl. ¶¶ 9-17.
12 Had ICE adequately revised its standards to protect medically vulnerable people as
13 required by the PI Order, those standards would have prohibited the dangerous
14 practice of interfacility transfers. Moreover, to the extent Defendants maintain that
15 transfers are necessary to prevent overcrowding or for other measures, such
16 measures can be more easily effectuated simply by releasing—rather than
17 transferring—people. Venters Decl. ¶ 13.

18 **C. Defendants' Failure to Implement Adequate Standards for**
19 **Quarantine and Medical Isolation Threatens the Subclass**

20 Defendants have likewise failed to promulgate necessary standards to ensure
21 that medically vulnerable people are not subjected to conditions equivalent to
22 solitary confinement as a means of medical isolation, quarantine, or other infection
23 control. See ECF 132 at 38 (requiring Defendants to develop a comprehensive
24

25 ¹² See *Hearing on Examining Best Practices for Incarceration and Detention*
26 *During COVID-19 Before the S. Comm. Of the Judiciary*, 116th Congress (2020)
(statement of Dr. Scott A. Allen, MD),
27 <https://www.judiciary.senate.gov/imo/media/doc/Scott%20Allen%20Testimony.pdf>.

28 ¹³ Madan, *supra* note 6.

¹⁴ Madan, *supra* note 6.

1 standard “for the safe detention of at risk detainees pending custody decisions, or
2 in the event ICE deems detainees ineligible for release”). To the contrary, the
3 attached declarations depict in disturbing detail how Defendants are dangerously
4 and inappropriately utilizing solitary confinement as means of infection control.

5 For example, after potential exposure to COVID-19, Plaintiff Ruben
6 Mencias Soto was placed in the disciplinary segregation unit of the Adelanto
7 Detention Center for two weeks. Mencias Soto Decl. ¶ 7. Mr. Mencias Soto was
8 locked down 23 hours a day with insufficient monitoring by medical and mental
9 health staff, and mere “pro forma” checks by security staff. *Id.* at ¶ 13; Haney
10 Decl. ¶ 20. Alarming, the same solitary confinement unit was used to quarantine
11 newly arrived people. Mencias Soto Decl. ¶ 7; Lienhard Decl. ¶¶ 8-9. This violates
12 CDC guidelines on quarantining. Haney Decl. ¶ 28.¹⁵

13 At the Aurora Detention Center in Aurora, Colorado, class member Oscar
14 Perez Aguirre describes living for roughly two weeks in the area of the facility
15 normally used for punitive solitary confinement upon returning from the hospital
16 due to COVID-19 infection and complications. Perez Aguirre Decl. ¶¶ 8-10.
17 Mr. Perez Aguirre was so weak that he could barely stand. While there, he had no
18 doctor’s appointments and no mental health checks. His request for something to
19 ease the burden of isolation, such as playing cards, was denied. *Id.* at ¶ 9. Further,
20 before he was taken to the hospital, he was living in a cell in the medical unit.
21 There, he was only allowed to leave to shower and had no reading material or
22 access to television. *Id.* at ¶ 4.

23 In addition, Defendants use extended, harmful lockdown as a means of
24 attempting to control the pandemic. For example, since March 2020, Plaintiff Alex
25 Hernandez has been locked in his cell at the Etowah Detention Center for nearly 20
26 hours a day or more, much of that time while sharing his cell with another person,
27

28 ¹⁵ Dr. Haney notes that both the CDC and both versions of the PRR are violated by numerous ICE practices like this one. Haney Decl. ¶¶ 14-15.

1 where social distancing is not possible. Hernandez Decl. ¶¶ 8-10. Mr. Hernandez
2 describes insufficient monitoring by medical and mental health staff and a rising
3 feeling of anxiety and stress during his months in lockdown. *Id.* at ¶¶ 9, 11.

4 The other evidence shows that these examples are far from anomalous but
5 rather systemic in nature. *See, e.g.*, Zwick Decl. ¶¶ 40-41; Rivera ¶¶ 26-27;
6 Doubossarskaia Decl. ¶ 35; Saenz Decl. ¶ 6; Page Decl. ¶ 15; Rios Decl. ¶ 19;
7 Corchado Decl. ¶ 27; Feldman Decl. ¶ 29.

8 As Dr. Haney’s expert declaration makes clear, the adverse implications of
9 the Defendants’ practices are profound. Class members are at significant risk of
10 grave harm, both because these practices do not, in fact, prevent the spread of
11 COVID-19 and because “lockdowns and solitary confinement subject persons to a
12 separate set of very serious harmful effects, ones that significantly undermine their
13 mental and physical well-being and risk doing far more harm than good.” Haney
14 Decl. ¶ 33. The mental health support offered to detained people subject to
15 Defendants’ isolation practices is insufficient, *id.* at ¶ 36, and the stark conditions
16 Defendants subject people to may deter them from reporting symptoms, potentially
17 exacerbating outbreaks. *Id.* at ¶ 5.F.

18 Imposing these conditions is not only dangerous to people’s physical and
19 mental health but also altogether unnecessary in order to achieve the objectives of
20 medical isolation and quarantine. Indeed, as Dr. Venters and Dr. Vassallo note,
21 both medical isolation and quarantine can and should be effectuated without
22 imposing conditions equivalent to solitary confinement. *See* Venters Decl. ¶¶ 14,
23 16, 29-40; Vassallo Decl. ¶ 33; *accord* ECF 132 at 5-6 (“[s]imple segregation or
24 solitary confinement measures as an outbreak management technique tend to
25 backfire: they result in less medical attention and increased chances of death”).¹⁶
26

27 ¹⁶ *See also, e.g.*, Dr. Brie Williams et al., *The Ethical Use of Medical Isolation—*
28 *Not Solitary Confinement—to Reduce COVID-19 Transmission in Correctional*
Facilities, AMEND (Apr. 9, 2020)

1 Despite having over two months to correct these dangerous omissions from its
2 PRR, Defendants' revised PRR continues to fail to provide necessary guidance to
3 ensure that solitary confinement is not improperly used in the guise of infection
4 control. Venters Decl. ¶¶ 29-41.

5 **D. Defendants' Revised PRR Still Threatens Subclass Members with**
6 **Exposure to Dangerous Disinfectant Cleaner**

7 As discussed above, the PI Order mandates that Defendants develop a
8 comprehensive response to ensure "safe detention" of people with Risk Factors
9 pending custody redeterminations. ECF 132 at 38. One critical aspect of such a
10 standard should be the proper and safe use of disinfectant cleaning supplies in the
11 detention centers. Venters Decl. ¶ 6. Defendants have issued no such standard.

12 To the contrary, reports from facilities throughout ICE's detention system
13 evince that cleaning measures are inconsistent and, when disinfectant is being
14 used, Defendants fail to ensure that detained people are not exposed to their harsh
15 and irritating effects. For example, at Adelanto, it has been repeatedly publicly
16 reported that staff are regularly spraying a harsh chemical agent in non-ventilated
17 areas, irritating vulnerable peoples' eyes, noses, and throats. *See, e.g.*, Gonzalez
18 Decl. ¶¶ 2-3; Valdez Bracamontes Decl. ¶ 5. Reports further indicate that the
19 chemical being sprayed is likely HDQ Neutral, which is not indicated for
20 household use. *Id.* at ¶ 4. Freedom for Immigrants, an advocacy group, has
21 received similar reports of harsh chemicals being used to disinfect at the Houston
22 Contract Detention Facility in Texas; at Glades Detention Center in Florida; and at
23 Yuba County Jail, which holds detained people for ICE, in California. Gonzalez
24 Decl. ¶ 2. At Glades, detained people have identified the spray as produced by the
25 same company as HDQ Neutral. *Id.* Similarly, providers at South Texas ICE
26 Processing Center report that their clients are having adverse reactions such as

27
28 https://amend.us/wpcontent/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.

1 coughing and sneezing to a chemical spray being used there. Russell Decl. ¶ 18.

2 These reports are inconsistent with Defendants' obligations under the
3 Court's order for several reasons. First, as Dr. Venters has noted, improperly using
4 disinfectant cleaning agents can disincentivize proper cleaning. Venters Decl. ¶ 6.
5 Second, this practice further endangers vulnerable class members by triggering
6 adverse physical responses to the chemical, and further straining medical resources
7 in the detention centers as detained people seek help for the bad reactions they're
8 experiencing. See Valdez Bracamontes Decl. ¶ 5. Although cleaning and
9 disinfecting are important components of infection control, Defendants must
10 ensure that proper disinfectants are utilized and that people are not dangerously
11 exposed to them during their use. Venters Decl. ¶ 6. This is yet another area where
12 Defendants completely disregard CDC recommendations and this Court's order by
13 refusing to develop and implement proper detention standards. Defendants' revised
14 PRR does not remediate this omission. *Id.*

15 **E. Defendants Have Failed to Issue Other Necessary Precautions to**
16 **Protect People with Risk Factors**

17 The deficiencies outlined above are merely illustrative of other dangerous
18 omissions in Defendants' COVID-19 response stemming from their delayed,
19 insufficient revision to the PRR. Indeed, as outlined in the attached declarations,
20 other dangerous conditions persist in the facilities, including failures to implement
21 social distancing, lack of PPE, and substandard healthcare. As detailed in the
22 declarations of Dr. Venters and Dr. Vassallo, there are numerous other
23 precautionary measures that Defendants should also implement to protect people
24 with Risk Factors from such dangerous conditions, which the revised PRR wholly
25 fails to address. These include but are not limited to: release of all people with Risk
26 Factors; twice daily screening of symptoms and temperature consistent with CDC
27 recommendations using a structured screening tool; development of care protocols
28 for detained people who test positive, particularly those with Risk Factors;

1 cohorting of high-risk detainees into specialized housing areas with enhanced
2 infection control measures and training among staff, who are assigned to these
3 units; healthcare evaluations by appropriately trained staff to assess high-risk
4 patients' current conditions, symptoms and medications, and to make a plan for
5 COVID-19 infection; increased social distancing measures and PPE for high-risk
6 people; increased medical and mental health surveillance of people with Risk
7 Factors, including contact tracing; expansion of testing to people with Risk Factors
8 and close contacts/staff; increased education of people with Risk Factors; enhanced
9 training of staff with any responsibility over people with Risk Factors; audits of
10 medical staffing ratios at facilities to ensure proper staffing where medically
11 vulnerable people are detained; hospitalization protocols for people with Risk
12 Factors. *See* Venters ¶¶ 7, 43-47; Vassallo ¶¶ 22-34. Defendants' revised PRR
13 wholly fails to address such crucial measures. *See id.*

14 **V. ICE Is Failing to Adequately Monitor the PRR**

15 This Court has made clear several times that ICE must engage in robust,
16 effective monitoring and oversight of the PRR. First, the PI Order required ICE to
17 "monitor and enforce facility-wide compliance with" revised or supplemental
18 Pandemic Response Requirements. ECF 132 at 30, 38-39. Second, after ICE
19 subsequently contended that the PI Order did not require "Defendants to track
20 anything concerning monitoring and enforcement of" the PRR, the Court described
21 that position as "nonsensical," and ordered ICE to produce, on an ongoing basis,
22 records regarding monitoring and enforcement of the PRR. ECF 150 at 6, 10.

23 Notwithstanding these admonitions, ICE continues to reluctantly engage in
24 lax oversight and monitoring that, to the extent that it exists at all, relies on the
25 same broken system that existed before the pandemic hit. ICE's monitoring of the
26 PRR consists solely of sending a bare-bones, incomplete questionnaire to each
27 detention facility, allowing facility staff to complete the form, and then having
28 Detention Service Managers ("DSMs") and Detention Standards Compliance

1 Officers (“DSCOs”) review the forms and conduct follow-up where they deem
2 necessary. Fox Decl. Ex. 18 at 10. This ineffective system allows an intolerable
3 level of risk to continue for many reasons.

4 First, the survey questionnaires omit important topics. For example, this
5 Court determined that one of the most “serious systemic deficiencies” by ICE was
6 its failure to have measures in place for the safe detention of at-risk individuals
7 (ECF 132 at 37), and for this reason, the Court ordered Defendants “to provide a
8 more concrete standard to protect” subclass members. ECF 150 at 6 n.2.
9 Nevertheless, the vast majority of questionnaires omit any questions concerning
10 the measures taken, if any, by each detention facility to protect medically
11 vulnerable people. Schlanger Decl. ¶ 47. Further, most of the questionnaires do not
12 ask for any information on such crucial preventative measures as the circumstances
13 under which testing should occur, or the number of tests. *Id.*

14 Second, relying on DSMs and DSCOs is the same ineffective approach to
15 monitoring and oversight that ICE used before the pandemic, one that has been
16 repeatedly criticized by OIG,¹⁷ and one that has led—as this Court pointed out in
17 its PI Order—to a long history of “monitoring and oversight failures.” ECF 132 at
18 30. Further, there is no reason to believe that DSMs and DSCOs have the
19 necessary medical training to be able to spot problems in questionnaires,
20 appropriately engage with the content required to answer the questions, or to
21 determine how to address those problems. Venters Decl. ¶ 59.

22 Third, even if DSMs were qualified to conduct follow-up about medical care
23 (they are not), ICE has not produced any information that any follow-up on the
24

25 ¹⁷ See, e.g., Office of Inspector Gen., U.S. Dep’t of Homeland Sec., OIG-18-67:
26 *ICE’s Inspections and Monitoring of Detention Facilities Do Not Lead to*
Sustained Compliance or Systemic Improvements at 2 (Jun. 26, 2018)
27 <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>;
28 Office of Inspector Gen., U.S. Dep’t of Homeland Sec., OIG-19-18: *ICE Does Not*
Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable
for Failing to Meet Performance Standards, at 5 (Jan. 29, 2019)
<https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>.

1 surveys has yet occurred, notwithstanding the clear need for such follow-up. For
2 example, many responses appear to be drafted by attorneys and do not at all
3 provide the requested information. Survey responses from GEO (a contractor for
4 ICE) make this clear by, for example, responding as follows to the question how
5 often are cleaners and disinfectants used on surfaces: “GEO is following applicable
6 sanitation policies, standards, CDC, and ICE guidance to determine the facility’s
7 sanitation schedule.” Fox Decl. Exs. 15, 16.

8 Finally, many questions simply ask whether a particular policy is in place,
9 but do not ask about the substance of that policy, or other necessary specific
10 information. Schlanger Decl. ¶ 55. For example, the surveys ask whether medical
11 procedures are in place governing such topics as handling infected/exposed
12 detainees, processing new admissions, and isolation, but there are no questions
13 asking for the substance of those policies. *Id.* This makes it impossible for anyone
14 reviewing these questionnaires to know whether or not the policies/procedures in
15 place at a particular facility comply with CDC or ICE protocols.¹⁸

16 **VI. Defendants Are Violating the Provisions of the PI Order Governing** 17 **Custody Redeterminations**

18 Defendants have further violated the PI Order by not ensuring that
19 meaningful custody redeterminations occur for of *all* detained individuals with
20 Risk Factors, and not making the presence of Risk Factor a significant factor
21 weighing in favor of release. The PI Order requires that:

22 “Defendants shall make timely custody determinations for
23 detainees with Risk Factors, per the latest Docket Review
24 Guidance. In making their determinations, Defendants should
25 consider the willingness of detainees with Risk Factors to be
26 released, and offer information on post-release planning, which
Plaintiffs may assist in providing.” ECF 132 at 38.

27 ¹⁸ Many of the questions are poorly phrased or difficult to understand. *See*
28 Schlanger Decl. ¶¶ 49-59, 60-61.

1 The Docket Review Guidance requires that the presence of Risk Factors “should
2 be considered a significant discretionary factor weighing in favor of release.”¹⁹
3 The Court later clarified that the aspects of the preliminary injunction with no
4 specified timeline “were intended to have immediate or near immediate effect, for
5 example, *that Defendants expand the categories of individuals eligible for custody*
6 *determinations under the Docket Review Guidance.*” ECF 150 at 6 (emphasis
7 added). This instruction, combined with the Court’s mandate that the PRR apply to
8 people with Risk Factors regardless of the statutory authority for their detention
9 (ECF 132 at 38), demonstrates that Defendants should have processes in place to
10 ensure swift custody determinations for *all* people with any Risk Factors with a
11 strong presumption of release to ensure their safety.

12 Further, Defendants must monitor and oversee this process. Indeed, the
13 Court rejected Defendants’ initial argument that the Court “did not order
14 Defendants to track anything.” ECF 150 at 6. Defendants continue to refuse to
15 maintain any centralized mechanisms to oversee and ensure consistent, compliant
16 custody redeterminations throughout their networks of detention facilities.

17 **A. Defendants Fail to Provide Adequate Oversight and Monitoring**
18 **to Ensure Custody Redeterminations Occur in Compliance with**
19 **the PI Order**

20 In the meet and confer discussions regarding compliance with the Court’s
21 orders, Defendants have confirmed that:

22 “ . . . other than as set forth in the March 27, 2020 and April 4,
23 2020 guidance letters, there is no *process in place covering*
24 *custody redeterminations*. Specifically, there are no protocols or
25 guidance addressing: (1) how detained individuals can seek
26 custody redeterminations; (2) which factors other than the
27 presence of a COVID-19 risk factor should be used in making
28 custody redeterminations, including those factors that weigh

¹⁹ ECF 121-4 at 2. Although the risk factors in that guidance referred to those described at the time by the CDC, the PI Order refers to the Risk Factors covered by the subclasses. See ECF 132 at 21-22, fns. 20, 21.

1 against release; (3) what weight should be placed on various
2 factors for purposes of determining whether detained individuals
3 should be released; and (4) whether a detained individual with
4 risk factors who is denied release should be informed of that
denial and the reasons for that denial” Fox Decl. Ex. 4. (emphasis
added).

5 Defendants also clarified that ICE has taken no steps to review custody
6 redeterminations to see whether they are being done correctly and consistently,
7 claiming that the PI Order does not require any process to be put in place
8 governing custody redeterminations.

9 **B. Defendants’ Lack of Oversight to Ensure Compliant and**
10 **Consistent Custody Redeterminations Has Led to Horrific Results**

11 As a result of Defendants’ failures in oversight, subclass members who seek
12 custody redeterminations pursuant to the PI Order are faced with a nebulous and
13 unpredictable process lacking meaningful review, as well as arbitrary and
14 inconsistent approaches across different facilities and field offices, resulting in
15 many extremely vulnerable people remaining detained and at extreme risk.

16 Evidence indicates that Defendants have failed to engage in meaningful
17 review of class members’ custody redetermination requests. First, multiple field
18 offices have denied custody redetermination requests within hours—and some
19 even within minutes—of their submission. *See, e.g.*, Zwick Decl. ¶ 11; Feldman
20 Decl. ¶ 13; Dobbins Decl. ¶ 12; Bailey Decl. ¶¶ 6, 10; *see generally* Gonzalez
21 Morales Decl. Even more field offices have refused to provide explanations for
22 why release is denied. Gonzalez Morales Decl. ¶ 8; Feldman Decl. ¶¶ 15-17;
23 Rivera Decl. ¶ 19. Some field offices issue denials using boilerplate language.
24 Feldman Decl. ¶¶ 10-18; Rivera Decl. ¶¶ 20-23; Schneider Decl. ¶ 8. Even those
25 that provide a modicum of individualized detail indicate a lack of meaningful
26 review.²⁰ For example, denials claiming to be based on *Fraiha*t reviews have been

27 ²⁰ *See, e.g.*, Edgerton Decl. ¶¶ 10, 22. For example, many requests were seemingly
28 automatically denied for class members with criminal records regardless of the

1 issued days before the related requests were submitted,²¹ and in one instance, the
2 Las Vegas Field Office denied two subclass members' release, claiming to have
3 conducted custody reviews under *Fraihat* on April 15, five days before the
4 preliminary injunction was issued. See Flewelling Decl. ¶ 13.

5 Second, few subclass members have been released under the PI Order,
6 further indicating Defendants' mere *pro forma* custody redetermination process.
7 Defendants reported that, as of June 19, 2020, only 1,909 of the nearly 6,000
8 identified subclass members have been released under the PI Order, leaving
9 approximately 67% of subclass members in ICE custody, including 2,735 subclass
10 members who are not subject to mandatory detention. Fox Decl. ¶ 10. Critically, it
11 appears that the actual number of releases under the PI order is substantially lower
12 than reported by Defendants. Of the 1,901 on Defendants' list of released class
13 members, 74 were identified as relief granted by order of immigration judges,²²
14 and 769 were deported. *Id.* ¶ 12. Notably, Defendants' *Fraihat* release list includes
15 "death" as a reason for release, listing three class members who died in custody
16 among those "released" under the PI Order.²³ In other words, Defendants are
17 inflating the number of releases pursuant to this Court's order. At the same time,

18
19 seriousness of their risk factors. Bailey Decl. ¶¶ 6-7, 10; Rios Decl. ¶ 11; Rivera
20 Decl. ¶ 23.

21 ²¹ Feldman Decl. ¶¶ 14-15.

22 ²² The subclass members listed as "released" under the preliminary injunction
23 include Marco Montoya Amaya, one of the *Fraihat* named plaintiffs, whose
24 custody redetermination was denied twice but who was later released on bail under
25 *Zepeda Rivas v. Jennings*, No. 20-CV-02731-VC, 2020 WL 2059848 (N.D. Cal.
26 Apr. 29, 2020). Fox Decl. ¶ 14. The list also incorrectly includes Adrian Rodriguez
27 Alcantara, who was released on judicial order under *Alcantara v. Archambeault*,
28 No. 20CV0756 DMS (AHG), 2020 WL 2315777 (S.D. Cal. May 1, 2020). Fox
Decl. ¶ 14.

²³ Carlos Escobar Mejia and Santiago Baten Oxlaj are listed among those released
under *Fraihat*, both of whom passed away in ICE custody from COVID-19. Fox
Decl. ¶ 13. The *Fraihat* release list also includes Choung Ahn, a 74-year-old class
member with multiple risk factors whose death is thought to have resulted from
suicide while he was quarantined in solitary confinement upon return to Mesa
Verde ICE Processing Center after hospitalization for severe chest pain. Fox Decl.
¶ 13.

1 the number of overall subclass members is likely much higher than that which
2 Defendants report (which evinces low releases overall). Indeed, Jose Baca
3 Hernandez, Ruben Dario Mencias Soto, and Alex Hernandez, all three *Fraihat*
4 named plaintiffs for whom Class Counsel submitted custody redetermination
5 requests that were denied, are excluded from Defendants’ produced list of class
6 members, as were others, strongly suggesting that Defendants have failed to
7 identify and review the custody status of countless other subclass members. Fox
8 Decl. ¶¶ 14,17. Defendants’ own records evidence their failure to meaningfully
9 implement the custody redetermination process.

10 Third, and as detailed further below, Defendants improperly bar anyone
11 subject to mandatory detention from release. But the PI Order requires
12 individualized redeterminations “regardless of the statutory authority for their
13 detention (ECF 132 at 38), and in any case, more than 70% of people Defendants
14 have refused to release are not subject to mandatory detention. Fox Decl. ¶ 11.

15 Defendants’ failure in oversight has also contributed to arbitrary and
16 inconsistent custody review across different facilities. While some facilities accept
17 custody redetermination requests via email,²⁴ others have insisted that requests be
18 submitted in hard copy by mail.²⁵ Some field offices appear to have established
19 their own “priority” for release.²⁶ Furthermore, some field offices have begun
20 refusing to acknowledge subclass members’ Risk Factors despite records of such,²⁷
21 and others have created barriers for subclass members to access their medical
22

23 ²⁴ Feldman Decl. ¶ 10; Russell Decl ¶ 8.

24 ²⁵ Gonzalez Decl. ¶ 19; Russell Decl. ¶ 8; King Decl. ¶ 8.

25 ²⁶ For example, the Otay Mesa Field Office denied a subclass member’s release
26 because they were “not the ‘agency’s priority’”. Rios Decl. ¶ 9. Similarly, the
27 Newark Field Office denied a subclass member’s release because the individual
28 was not on a “list” of people with certain conditions. Gonzalez Decl. ¶ 17.

²⁷ For example, though a subclass member submitted medical records
corroborating their Risk Factor, the San Francisco Field Office denied release due
to “no evidence of complications.” Gonzalez Decl. ¶ 23.

1 records while in custody, which wholly prevents them from substantiating their
2 claims that they have Risk Factors warranting release.²⁸ Lastly, while some
3 facilities and field offices respond within minutes of requests being submitted,
4 others take weeks to respond or fail to respond at all. *See* Bailey Decl. ¶¶ 6, 10;
5 Gonzalez Decl. ¶ 15. Feldman Decl. ¶ 11; Saenz Decl. ¶ 16; Rios Decl. ¶ 9; Rivera
6 Decl. ¶ 16. Overall, Defendants’ lack of oversight has contributed to a confusing
7 “patchwork” response, leaving thousands of class members at continued risk of
8 infection, death, or complication by COVID-19. *See* Gonzalez Decl. ¶ 6.

9 **C. Defendants Refuse to Consider for Release Subclass Members**
10 **Subject to Mandatory Detention in Violation of the PI Order**

11 This Court’s PI Order makes clear that its remedial provisions apply equally
12 to all subclass members regardless of the statutory basis for their detention. *See,*
13 *e.g.*, ECF 132 at 10, 38; ECF 150 at 3. Yet, Defendants continue to maintain that
14 the mandatory detention provisions of INA § 236(c) continue to apply and that
15 people in detention subject to these provisions may not be released pursuant to
16 *Fraihat* even if they have Risk Factors for serious illness from COVID-19. *See*
17 ECF 121-4 at 2; ECF 146 at 21; Fox Decl. Exs. 1, 2. In addition to Defendants’
18 express admissions, it is clear that this bar is being implemented throughout the
19 country. *See* Zwick Decl. ¶ 12 (denials for criminal history), ¶ 14 (ICE says “waste
20 of time” to request release for people with criminal histories), ¶ 27 (criminal
21 history leads to *per se* denial); Russell Decl. ¶¶ 10-13 (blanket denials for anyone
22 with a criminal history at Pearsall, with no change since the new order has been
23 issued), ¶ 15 (same at Laredo); Schneider Decl. ¶ 12.

24
25
26
27 ²⁸ For example, the South Texas ICE Processing Center and Laredo Detention
28 Center abruptly modified their policy such that ICE would no longer release
records to attorneys, only to the detained people themselves. Of note, this policy
change occurred within a week of notices regarding the PI Order being posted at
the facilities. Russell Decl. ¶ 9.

D. Defendants Fail to Conduct Custody Redeterminations for All People with Qualifying Severe Psychiatric Illnesses

Defendants have also violated the Court’s Order by issuing unnecessarily stringent guidelines on the Risk Factor of “severe psychiatric illness.” The Court’s PI Order required Defendants to “provide ICE Field Office Directors with the Risk Factors identified in the Subclass definition” and to “provide necessary training to any staff tasked with identifying detainees with Risk Factors” (ECF 132 at 38). The Risk Factors listed in the PI Order included “severe psychiatric illness” (ECF 132 at 21 n.20 and 22 n.21). The guidance that Defendants sent to field office directors on April 28, 2020 directed they interpret “severe psychiatric illness” as “defined in *Franco-Gonzalez v. Holder*, 2013 WL 8115423 (C.D. Cal. 2013), to include: (1) Psychotic Disorder; (2) Bipolar Disorder; (3) Schizophrenia or Schizoaffective Disorder; (4) Major Depressive Disorder with Psychotic Features; (5) Dementia and/or a Neurocognitive Disorder; (6) Intellectual Development Disorder (moderate, severe or profound).” Fox. Decl. Ex. 19; *see also id.* Ex. 2 at 2. This list is based on an inapposite legal situation—competency in immigration proceedings—and fails to account for the risks that people with other severe psychiatric illnesses face as a result of COVID-19.

Psychiatric illness is relevant to this case because it is “especially difficult for psychiatrically vulnerable persons to initiate and consistently maintain” the “preventive strategies depend[ing] heavily on various forms of self-care” that are necessary to prevent the spread of the virus. Haney Decl. ¶ 10; Vassallo Decl. ¶ 18; Venters Decl. ¶ 32. The importance of consistency in maintaining these precautionary measures over many months means that “those who are diagnosed as mentally ill or those with sub-clinical symptoms such as depression or anxiety [] are especially vulnerable in the Pandemic.” Haney Decl. ¶ 7. Post-traumatic stress disorder, anxiety, and depression are a few examples of psychiatric illnesses that may make someone vulnerable to COVID-19 that ICE’s directive fails to include.

1 See Haney Decl. ¶ 8; Venters Decl. ¶ 32. In addition, dementia or subclinical
2 symptoms like confusion, distress, or pain may make it difficult for a COVID-19
3 patient to participate in their care or express symptoms, increasing their risk of
4 complications from the virus. See Vassallo Decl. ¶ 18. Defendants' narrow
5 definition continues to place subclass members with psychiatric illness in harm's
6 way.

7 **VII. A Special Master Is Necessary in Light of Defendants' Non-Compliance**

8 This Court has the authority to appoint a special master under Fed. R. Civ. P.
9 53(b) and the All Writs Act (28 U.S.C. § 1651(a)) to monitor compliance with the
10 PI Order. Appointment of a special master is appropriate where, as here, the
11 underlying injunction enjoins systemic conduct; the case is complex; the defendant
12 has violated the injunction and there is a strong prospect of future noncompliance;
13 and there are ongoing disputes regarding the implementation of the court's orders.
14 See *Flores v. Sessions*, No. CV 85-4544-DMG, 2018 WL 6133665, at *2 (C.D.
15 Cal. Nov. 5, 2018); *Melendres v. Arpaio*, 784 F.3d 1254 (9th Cir. 2015); *Coleman*
16 *v. Wilson*, 912 F.Supp. 1282, 1324 (E.D. Cal. 1995).

17 An exceptional condition under Rule 53(b) does not require a final
18 determination of a constitutional violation or a determination of intentional
19 disregard of court orders. In fact, the complexity of compliance with a court's
20 order itself can be sufficient to warrant the appointment of a monitor, and no
21 finding of prior noncompliance is necessary in such circumstances. See *Nat'l Org.*
22 *for the Reform of Marijuana Laws v. Mullen*, 828 F.2d 536, 542 (9th Cir. 1987)
23 (holding that "the prospect of noncompliance is an 'exceptional condition' that
24 justifies reference to a master"). Although actual noncompliance is not necessary
25 for the Court to appoint a special master, a history of noncompliance may require
26 that a court appoint a monitor to ensure an agency's compliance moving forward
27 where the court determines that it lacks the resources to constantly monitor the
28 agency's compliance directly. See *Hook v. State of Ariz.*, 120 F.3d 921, 926 (9th

1 Cir. 1997) (affirming appointment of monitor where district court had determined
2 “it lacked the resources to constantly monitor compliance with the decree, as it was
3 required to do because of the Department’s noncompliance”).

4 Applying these principles here, the evidence demonstrates the need for a
5 Special Master to ensure Defendants’ compliance. In addition to the complexity of
6 this case, the evidence above demonstrates Defendants’ ongoing noncompliance
7 with the PI Order. The parties’ disputes as to the implementation of the PI Order
8 and the risk of future noncompliance further militate in favor of a Special Master.

9 **VIII. Defendants’ Failure to Respond to the Severe Risks Addressed in the PI**
10 **Order Warrants a Presumption of Release for Subclass Members**

11 Defendants’ slow-walk approach in the wake of a fast-moving pandemic—in
12 particular, their delayed issuance and lax enforcement of performance standards to
13 protect detained persons with Risk Factors, as well as their deficient and
14 inconsistent approach to required custody determinations—has created an
15 immediate need for additional action. Defendants’ inaction means that detained
16 people with Risk Factors are still facing the same, if not greater, risks as those
17 faced prior to the issuance of the PI Order. This is especially true given
18 Defendants’ ongoing failures to include medically necessary precautions in its
19 revised PRR, as detailed by Dr. Venters and Dr. Vassallo. As a result, with respect
20 to custody determinations, a presumption of release is necessary to ensure that
21 Defendants fully comply with the custody determination requirements of the PI
22 Order, including ensuring that *all* subclass members are assessed, with the
23 presence of a Risk Factor weighing heavily in favor of release.²⁹

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28 ²⁹ This inclusion of this presumption is necessary to “achieve the purposes” of the
original injunction. See *United Shoe Mach. Corp.*, 391 U.S. at 249.

IX. Conclusion

For these reasons, and in light of Defendants' continued non-compliance with the PI Order, Plaintiffs respectfully request that the Court grant the Motion to Enforce and order the remedies requested in the proposed order.

DATED: June 24, 2020

Respectfully submitted,

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**[Proposed] Order Granting
Plaintiffs' Motion to Enforce the
Court's April 20, 2020 Preliminary
Injunction**

1 Upon this Court's thorough review of Plaintiffs' Motion to Enforce, the
2 evidence in support, and Defendants' response, the Court hereby GRANTS
3 Plaintiffs' Motion to Enforce the Preliminary Injunction Order and ORDERS as
4 follows:

- 5 1) Within 10 days of this order, Defendants shall release all subclass 1
6 and subclass 2 members that remain in ICE custody unless
7 Defendants—through revised custody redeterminations conducted for
8 Subclass members whom ICE intends to keep in custody—establish
9 by individualized evidence both that a subclass member poses a
10 danger to the community or a risk of flight and that the subclass
11 member will be provided adequate medical care and detention
12 conditions to ensure their safety during the COVID-19 pandemic if
13 not released. In conducting these redeterminations, Defendants shall
14 ensure that the presence of a Risk Factor constitutes a significant
15 factor weighing in favor of release. This applies to all subclass
16 members with Risk Factors regardless of the statutory basis of their
17 detention (e.g., mandatory detention). That a subclass member is
18 subject to mandatory detention is, standing alone, not a categorical
19 basis to deny release. Defendants shall also ensure that they evaluate
20 all subclass members with Severe Psychiatric Illnesses as defined by
21 Plaintiffs' medical experts, and Defendants shall issue revised
22 guidance correcting and expanding their previous guidance
23 concerning subclass members with Severe Psychiatric Illness.
24 Defendants shall provide individualized explanations in writing
25 explaining the basis for any continued detention. Written explanations
26 shall be provided to the Special Master for review.
- 27 2) Appointment by the Court, through a subsequent order pursuant to
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1 Rule 53 of the Federal Rules of Civil Procedure, of one or more
2 Special Masters for the purposes of:

3 a. Overseeing the custody redetermination process of subclass 1 and
4 subclass 2 members that remain in ICE custody pursuant to the PI
5 Order and updated order described directly above. The Special
6 Master should ensure that in conducting custody redeterminations,
7 the presence of a Risk Factor is considered by ICE to be a
8 significant factor weighing in favor of release, and that ICE is
9 considering for release all people with Risk Factors
10 (notwithstanding mandatory detention status), including all people
11 with severe psychiatric illness as defined by Plaintiffs' medical
12 experts. If a determination is made that a subclass member will
13 remain in ICE's custody, the Special Master shall oversee the
14 development of procedures for providing subclass members
15 written notice and the basis for continuing detention.

16 b. Overseeing ongoing updates of the Pandemic Response
17 Requirements (PRR) to establish the minimum acceptable
18 detention conditions necessary to reduce the risk of COVID-19
19 infection to subclass members as well as providing proper
20 treatment and monitoring of subclass members if they become
21 infected. At a minimum, those standards shall include the
22 precautions outlined in the expert reports of Dr. Homer Venters,
23 Dr. Susi Vassallo, and Dr. Craig Haney, including but not limited
24 to: a plan for the immediate implementation of universal and
25 ongoing testing in all ICE facilities; prohibitions on unnecessary
26 inter-facility transfers; prohibitions on the use of conditions
27 equivalent to solitary confinement for purposes of medical
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1 isolation, quarantining, and infection control; safe use of
2 cleaning/disinfectant; increased social distancing protocols for
3 subclass members; increased access to PPE for subclass members
4 and staff who work with them; a plan for increased and accelerated
5 medical and mental health monitoring and surveillance of people
6 with Risk Factors; audits of medical staffing levels at facilities;
7 increased training concerning COVID-19 precautions of all staff
8 with responsibility over people with Risk Factors; twice daily
9 temperature and symptom checks of all people with Risk Factors
10 and development of a screening tool; a plan for regular distribution
11 of clinical guidance for treatment of COVID-19 to all facilities;
12 implementation of a hospitalization protocol; and promulgation of
13 protocols to ensure that subclass members have a pre-infection
14 COVID-19 clinical plan, increased monitoring during infection,
15 and recovery planning. These additional precautions are illustrative
16 and not exclusive. Further, the PRR should regularly be assessed
17 and amended to reflect updated clinical guidance, best practices
18 and research.

19 c. Overseeing implementation of oversight and monitoring of the
20 PRR pursuant to the Court's PI Order.

21 3) Within 10 days of this Order, Defendants shall provide to Plaintiffs'
22 counsel all records required to be provided by the Court's May 15,
23 2020 Order (ECF 150) that have not previously been provided but that
24 are currently in Defendants' custody, possession, or control. Future
25 spreadsheets provided pursuant to paragraph 3 of the May 15 Order
26 shall also include fields indicating whether each person (a) has been
27 tested for COVID-19, and (b) whether the test results are positive,
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negative or not yet determined.

IT IS SO ORDERED.

DATED: _____

The Honorable Jesus Bernal
UNITED STATES DISTRICT JUDGE

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16 **UNITED STATES DISTRICT COURT**
17 **CENTRAL DISTRICT OF CALIFORNIA**
18 **EASTERN DIVISION – RIVERSIDE**

19 FAOUR ABDALLAH FRAIHAT, *et al.*,
20 Plaintiffs,

21 v.

22 U.S. IMMIGRATION AND CUSTOMS
23 ENFORCEMENT, *et al.*,

24 Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF ALEX
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27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF ALEX HERNANDEZ

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

1. I am at least 18 years of age and I am competent to make this declaration.
2. My name is Alex Hernandez. I am 49 years old and I am originally from Honduras. I have been in ICE custody since approximately October 2019. I am currently detained at Etowah County Detention Center in Gadsden, Alabama.
3. I am a Plaintiff in this case. I am also a subclass member given that I have hypertension, a risk factor for COVID-19. I also have Barrett's esophagus, which puts me at a higher risk for cancer. I have not had an endoscopy or biopsy since being in ICE custody, which is meant to be conducted yearly to monitor my Barrett's esophagus and detect potentially cancerous cells. In addition, I had a shoulder surgery in November I am still recovering from. Although I am taking medication to manage my pain, I am still experiencing pain, weakness, and inflammation from the surgery. Since the COVID-19 outbreak, I have not received physical therapy and have not been evaluated by a specialist. I am not able to continue my physical therapy exercises that were ordered by the doctor because I am in so much pain.
4. In mid-May, I started to experience an intense pain from a broken tooth. I immediately brought this to the attention of Etowah staff. I was told I would be put on the list to see the dentist urgently. At Etowah, dentist appointments are scheduled for Fridays and I was finally scheduled for an appointment for Friday, June 5, 2020. I was never called for the appointment. I filed a new medical request after Etowah staff canceled my appointment without a reason and failed to provide me medication for my tooth pain. As of June 10,

2020, I have not been able to reschedule an appointment with the dentist to get my tooth fixed or receive pain medication.

5. There has been no change in protocols or procedures in place in light of COVID-19 at Etowah. Detained people in charge of cleaning the common areas lack cleaning materials. When the facility refills the hand soap, it is usually gone by the next day. We then have to wait another week for Etowah staff to refill the hand soap. We only have shampoo to clean ourselves.
6. At Etowah, staff does not enforce detained people to wear masks. Some detained people do not wear their mask. I always wear a mask. I have had the same mask for over two months—I have only been given one mask since the COVID-19 outbreak. It is dirty and used. Staff facility started wearing masks around the beginning of May. I have not seen any officers wearing gloves.
7. I have not witnessed any changes in the medical staff at Etowah in light of COVID-19, such as increased staffing.
8. I am locked in a cell by myself approximately 19.5 hours a day. Until the end of May, I shared my cell with another individual. Until he moved to another cell, we were locked in a cell together for 21 hours a day/ 7 days a week for over a month. It was extremely stressful being isolated with another person in such confined quarters. Other people in the dorm continue sharing a cell under lockdown. All we have is old national geographic magazines and the Bible to read. We are not given any other books to read. At Etowah, the only books we have access to are from the visitation group who can no longer come to the facility. For the 19.5 hours, all I do is read the magazines, listen to the radio, and sleep.

1 9. My dorm is let out of lockdown approximately 4.5 hours a day. There are
2 two floors in the dorm. The staff let people out by floors. There are
3 approximately 40 people in each floor. We have ten minutes to eat each
4 meal where we have to rush to eat quickly. We are let out of lockdown for
5 an additional hour in the morning, an hour in the afternoon, and an hour and
6 a half in the evening. During the time out of the dorm, I use the time to
7 shower, visit the law library, watch television, use the phone, and go to
8 recreation. When we come out for recreation, people are arguing with
9 another and are very stressed. It is very difficult to be in confinement all day.
10 I am also very stressed and anxious. I spent most of the day sad and worried
11 about what is going to happen to me.

12 10. It is impossible to have social distancing practices at Etowah while eating
13 because there are four of us sitting in the table at the same time. Social
14 distancing practices in the entertainment room are also impossible because
15 the room only has three couches for a group of 40 people.
16

17 11. Nurses have never come by to take our temperature once a day and I have
18 never received a COVID-19 test. Medical staff told us they only have testing
19 kits available for the sickest people.
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21 12. As a named plaintiff, to the best of my ability, I have been working with my
22 lawyers to help them prepare and work on this case. I will continue to do so.
23 I am available to them to assist with the case, and they are available to me to
24 answer questions and to explain and keep me updated on the litigation. I
25 regularly speak with my attorneys and their staff to provide them information
26 in support of this lawsuit. I have responded and will continue to respond to
27 the lawyers' requests for information about adequate health care and other
28 conditions of confinement to the best of my ability. I intend to continue

1 working zealously with my attorneys on behalf of other individuals detained
2 in ICE custody nationwide as long as I am a named plaintiff.

3 13.I seek only declaratory and injunctive relief on behalf of the subclass I am
4 not seeking monetary damages, and I understand that this civil case will not
5 result in the dismissal of my civil immigration proceedings against me or
6 others.

7
8 I declare under penalty of perjury that the statements above are true and correct to
9 the best of my knowledge. I have given my attorney permission to sign this
10 declaration on my behalf due to the pandemic.

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12 Signature:

13  Maia Fleischman on behalf of Alex Hernandez
14

15 Date: 6/11/2020
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1 I, Maia Fleischman declare the following under penalty of perjury pursuant to 28
2 U.S.C. § 1746 as follows:

- 3 1. I am a licensed attorney in good standing in Florida. I am an attorney of
4 record in *Fraihat v. ICE*, Case 5:19-cv-01546 (C.D. Cal.).
- 5 2. Out of necessity in light of the COVID-19 pandemic, I signed the attached
6 declaration on Alex Hernandez's behalf with his express consent.
- 7 3. ICE is requiring legal visitors to provide and wear personal protective
8 equipment, including disposable vinyl gloves, surgical masks, and eye
9 protection while visiting any detention facility. These supplies are not easily
10 accessible, given the increase in demand. Any available supplies are
11 prioritized to hospitals and other medical facilities that are still experiencing
12 shortages. As such, it is extremely difficult to arrange an in-person legal visit
13 while this policy is in effect. The policy has not been updated since April 2,
14 2020.
- 15 4. There are documented cases of COVID-19 in all fifty U.S. states and most
16 inhabited U.S. territories. The Center for Disease Control and Protection
17 (CDC) issued statements warning that individuals are at a higher risk of
18 infection when traveling. Mr. Hernandez is detained at Etowah County
19 Detention Center in Gadsden, Alabama, while I live in Miami, Florida.
20 Etowah has been on lockdown for approximately two months. In addition,
21 there have now been two known COVID-19 related deaths in ICE detention
22 centers and 1,392 confirmed cases of COVID-19 among detained people in
23 ICE custody with 2,670 people tested. There are 44 confirmed cases among
24 ICE employees working in ICE detention facilities.
- 25 5. In light of the above, to protect public health, I am not able to travel to
26 Etowah to obtain Mr. Hernandez's signature.
- 27 6. I spoke with Mr. Hernandez over the phone. Mr. Hernandez's has confirmed
28 that I can sign on his behalf as reflected in his declaration.

1 I declare under penalty of perjury that the statements above are true and correct to
2 the best of my knowledge and that this declaration was executed on June 11, 2020
3 in Miami, Florida.

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7 Maia Fleischman
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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF ALLYSON
PAGE**

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*Admitted Pro Hac Vice

**Pro Hac Vice Application Forthcoming

DECLARATION OF ALLYSON PAGE

I, Allyson Page, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Allyson Page. I serve as Deputy Director at Immigration Services and Legal Advocacy (ISLA). ISLA is a legal services organization that defends the rights of our immigrant communities and advocates for just and humane immigration policy. Our justice system's core principle is that of due process, where everyone has a fair and meaningful opportunity to be heard. We look forward to the day when no immigrant has to appear before an immigration court without a representative. ISLA attorneys visit detained immigrants at the Pine Prairie ICE Processing Center on a weekly basis and provide pro bono representation under a universal representation model before the Oakdale Immigration Court. Through this service, ISLA ensures that detained immigrants' due process rights are protected and that our clients do not have to attend these hearings and present their cases on their own.
2. ISLA primarily serves detained immigrants at Pine Prairie ICE Processing Center (PPIPC) in Pine Prairie, Louisiana. We also serve all of the detention centers in the Mississippi/Louisiana region to a lesser capacity both as part of a collaborative project to assist with release via parole, and as a result of the frequent transfer of clients from one detention center to another.
3. Since the outbreak of the COVID-19 pandemic, I have been in continuous contact with detained individuals at the facilities we serve. I have met with clients via VTC video chat between two and three times per week since the start of the pandemic. I have also spoken to clients via my work cell phone, as the line is free of charge when dialed from PPIPC. I have also received legal mail including hand written letters describing conditions in detail from clients in other detention centers where communication is more difficult.
4. I am familiar with the Fraihat subclasses pursuant to the April 20, 2020 order.

Custody Redetermination Requests

5. Based on ISLA's knowledge and experience, ICE is not conducting individualized custody determination requests pursuant to the April 20, 2020, order.
6. As of June 16, 2020, our staff have filed custody redetermination requests for approximately 13 individuals at the PPIPC facility. The PPIPC facility is under the New Orleans Field Office.
7. The process has been extremely challenging and confusing. Initially we were told to send emails to the deportation officer (DO) assigned to the case. The only way one can know who the deportation officer who is assigned to that particular case, is from a list that is posted inside the detention center. At that time the detention center was closed to visitors and one could only meet with clients via video or telephone. Our office had hand copied the list from within the detention center, as one may not enter with any camera or other recording device, but it became quickly apparent that the list had changed. When we sent emails to a DO whose case assignment had changed, they did not inform us that they were no longer working on the case and did not forward the case on to the appropriate DO, despite our specific request for them to do so. Our requests for the new docket list, as this list is known, have gone unanswered.
8. The only way to discover who the new DO assigned to the case was to speak to a supervising officer or SDDO and ask them directly. Often there was no response whatsoever until we had followed up several times and forwarded the emails to various officers. On average we waited between three weeks for an initial response. At some point during the last several months my colleague, Homero López, Jr., was informed by SDDO Carl Rupard that electronic parole filings were not accepted and they must be mailed or faxed. We heard from other attorneys that they too had received the same message. Then we heard that we could send them via email again. None of this was ever communicated in a formal way such as on a website, or sent out to an email listserve. All of the information gathered was shared through attorney listserves after individual attorneys had conversations with individual DOs or SDDOs.

1
2 9. We are not informed of any aspect of the review process. ICE simply sends a
3 decision without any prior communication. We have never been contacted
4 about a *Fraihat* release request, or asked for particular information, or
5 informed as to which documents were reviewed. Most of the denials come
6 on a uniform ICE document entitled "Notification Declining to Grant
7 Parole" which has checkboxes for the reason(s) behind the denial. Most
8 denials simply have the box which states that the parole request has been
9 previously denied and no new documentation nor changed circumstances
10 have been presented from the previous denial. When we ask specifically
11 about whether the *Fraihat* order has been taken into consideration when
12 making the determination that there are "no changed circumstances" we are
13 informed that "all factors have been taken into account." A couple of our
14 requests were denied on a new form titled "Interim Notice Declining Parole"
15 which seems to have been created in response to ongoing litigation as it had
16 an additional checkbox which listed court ordered reasons for release, such
17 as medical vulnerability or being pregnant.

18 10. On May 9, 2020, we filed a *Fraihat* redetermination request for a 54 year
19 old man who has a history of Chronic Obstructive Pulmonary Disease
20 (COPD) and submitted evidence of his medical history of COPD. On May
21 22, 2020, after following up a third time about the request, we received an
22 emailed copy of the Notification Declining to Grant Parole, dated May 18,
23 2020. The boxes checked were that our client was a flight risk and that there
24 was a previous denial and there had been no new evidence nor changed
25 circumstances since the previous denial dated February 19, 2020. When we
26 requested a copy of the previous parole packet to cross-reference, since it
27 was filed pro se, we were informed that we could request it through a
28 Freedom of Information Act (FOIA) request.

29 11. On May 28, 2020, we requested a supervisory review of the that denial,
30 particularly focusing on the fact that it was impossible that the stated reason
31 for denying the request was that there were no changed circumstances or
32 new documentation when the medical documentation was not previously
33 submitted and the *Fraihat* order had not been issued at the time of the
34 previous denial. On June 11, 2020, my colleague, Homero López, Jr., spoke
35 with Alcide Benoit, Interim Acting Oakdale Assistant Field Office Director

(AFOD) about this matter. After much back and forth about how the Fraihat order inherently created changed circumstances for someone who met the class definition, as well as how it was impossible to say that there were no new documents given that documents which were not submitted nor physically available to our client at the time of the previous request were submitted with the May 9, 2020, request, Officer Benoit finally informed Mr. López that a new request needed to be filed and that Officer Benoit would personally review it. That request is currently pending.

12. One of our clients was informed that he would be released from detention because of his health conditions. He has severe cardiac disease and has had multiple heart attacks. On or about May 15, 2020 we were informed that he would not be able to leave because he is mandatorily detained and no other basis for denial was provided.

Conditions of Detention

13. As of June 16, 2020, our staff have confirmed that people with risk factors at PPIPC are not being provided with sufficient room to practice social distancing.
14. Clients have reported that they still do not have access to sufficient soap, hand sanitizer or cleaning supplies to wash themselves and their living areas.
15. Clients have reported that they are being confined 22 or 23 hours a day to their cells. Solitary confinement has been used frequently as a means of addressing mental health issues, and the need for distancing as a result of the Covid-19 pandemic. We have learned that people are being placed in conditions equivalent to punitive solitary confinement for both 1) medical isolation of confirmed COVID cases and 2) for purposes of quarantining non-positive people. Units previously designed for solitary confinement have become the “medical” unit where those with confirmed cases of Covid-19 are sent to be isolated from the rest of the population and the unit where they were in prior to that is put on lockdown. One of our clients was taken out of the facility to a specialist physician after he repeatedly reported heart attack symptoms. When he returned from the physician, he was placed in solitary confinement for two weeks as a means of quarantine. Another client reported to a physician in the detention center that he felt extremely

1 depressed and fearful as a result of the Covid-19 pandemic, and that he
2 wanted medication because he felt like it wasn't worth living in these
3 conditions. He reported that he was not immediately provided with
4 medication, and that he was stripped nude and placed in solitary
5 confinement without a blanket. Clients report that the conditions in solitary
6 are the same as the conditions of punitive solitary confinement prior to the
7 COVID-19 pandemic.

8 16. Clients have reported that new people continue to arrive at PPIPC detention
9 center as recently as June 16, 2020. People are being transferred from other
10 detention centers, from jails and prisons. Clients have reported that people
11 arrived from the detention center in Alexandria, where there were a very
12 high number of reported cases, and they were placed in the general
13 population. Furthermore, clients have reported that people were taken to the
14 airport in Alexandria in an attempt to remove them to their country of origin,
15 and then when their country of origin refused to accept them, they were
16 returned to PPIPC and placed in the general population, despite the high
17 likelihood of exposure to the virus.

18 17. When we speak to our clients on VTC's, we have noticed that the guards do
19 not regularly clean the video area, equipment, or chair between clients.
20 Sometimes our clients request the guards to clean the area before they enter,
21 and the guards refuse or reply with frustration. We have reached out to the
22 facility administrator on three different occasions and received no response.

23 18. Our clients have reported that as of June 16, 2020 staff and detainees are still
24 not wearing surgical masks at all times. Many detained individuals have
25 asked for masks and have not received them or been asked to sign some
26 form of waiver in order to receive them.

27 19. Clients have reported that as of June 16, 2020, detained individuals are not
28 wearing gloves. Detained individuals have asked for gloves and have not
received them. Staff wear the same gloves for hours at a time and touch
multiple surfaces during this time.

20. ISLA is aware of dozens of people who are still being detained at PPIPC
who are elderly or immunocompromised due to diabetes, high blood

1 pressure, and other underlying medical conditions that put them at high risk
2 of contracting and suffering deadly consequences from COVID-19. PPIPC
3 has not released them despite the *Fraiha* order and ICE directives to release
4 medically vulnerable people and the elderly. One client of ours is in his 50's
5 and has had multiple heart attacks. A physician visited with him and referred
6 to him as a "walking heart attack" and at immediate risk of death. Last week,
7 a client who had tested positive for COVID-19 less than two weeks ago was
8 placed in the same cell with our client. He sat on our client's bed several
9 times and came into close contact with our client many times. Our client
10 began to feel ill and requested a medical visit. After the medical visit, our
11 client, along with all of his cell, were placed under quarantine.

12 21. I, along with the other members at ISLA, are extremely concerned by ICE's
13 response to the pandemic. We fear for the safety and well-being of the
14 detained individuals at the facilities we serve. We continue to be deeply
15 frustrated and horrified by the lack of efforts ICE and its contractors have
16 made to release vulnerable people and ensure safe conditions for those that
17 remain in their custody. We fear that its actions are putting hundreds of
18 individuals at serious risk of harm or death.

19 I declare under penalty of perjury and under the laws of the United States, pursuant
20 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
21 knowledge, memory, and belief.

22 Executed on the 6/22/20 in the year 2020, in the city of New Orleans, Louisiana.

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Allyson Page
Immigration Services and Legal Advocacy

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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

DECLARATION OF ANNE RIOS

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26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF ANNE RIOS

I, Anne Rios, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Anne Rios. I am a licensed attorney in good standing, in the state of California. I have been practicing law since 2009. I am a supervising attorney with the nonprofit organization Al Otro Lado (AOL).
2. AOL is a legal services organization that serves indigent migrants, refugees, deportees, and their families, and operates primarily in Los Angeles, California; San Diego, California; and Tijuana, Mexico; although it provides referrals and assistance to indigent migrants and refugees across the United States.
3. AOL's mission is to coordinate and provide screening, advocacy, and legal representation for individuals in immigration proceedings; to seek redress for civil rights violations, including disability rights violations; and to provide assistance with other legal and social service needs.
4. Specifically, AOL represents detained migrants in their removal proceedings; this includes representing individuals detained at the Otay Mesa Detention Facility.
5. Since the outbreak of the COVID-19 pandemic, a team of myself, a staff attorney, and three legal support staff have been in continuous contact with detained individuals at OMDC. Currently, OMDC has over 250 positive cases of COVID-19. The detainees are not able to practice social distancing and have not been giving proper protective gear. Because it is unsafe, attorneys have been disallowed from having contact visits with clients. Attorneys are allowed video teleconferencing with clients, but due to the fact that entering OMDC poses significant health risks to employees it is agency policy to communicate by phone with our clients.
6. I am familiar with the Fraihat subclasses pursuant to the April 20, 2020 order.

Custody Redetermination Requests

7. Based on AOL's knowledge and understanding, ICE is not conducting individualized custody redetermination reviews pursuant to the April 20, 2020 order.
8. As of June 2, 2020 our staff have filed 25 *Fraihat* parole requests for individuals at the OMDC facility. OMDC facility is under the San Diego-Otay Mesa Field Office.
9. Out of the over 25 individuals we have filed parole requests for, we have heard back for three (3) clients; two were denials based off of prior criminal history, with limited or no reference to their multiple risk factors. One client had diabetes, high blood pressure, and a fungal infection on buttocks; the other is a past smoker, has history of asthma and high blood pressure. For some clients, we have been waiting almost two months for a determination. The most recent denial, attached as Exhibit A, was because it was not the "agency's priority" even when the client had no criminal history.
10. With the aforementioned parole denial ICE did not detail what documents they reviewed, did not detail who did the review, and did not ask for any individualized information.
11. Based on our observations from the requests we have submitted under *Fraihat*, it is AOL's belief that clients who remain detained are those that have previous criminal history or have medical conditions that are not explicitly listed in the *Fraihat* order, for instance active tuberculosis (which could be a qualifying respiratory condition) or having tested positive for COVID-19. We have observed blanket denials for all our clients with a criminal history or those subject to mandatory detention, regardless of how serious the clients' medical conditions are.
12. Once individuals test positive for COVID-19 inside of OMDC, it has been reported to us from clients that they are placed in a medical unit where other COVID-19 positive individuals are placed. Individuals are instructed to clean the room themselves but were not provided with additional

1 instructions. The beds inside the “quarantined” room are one arm’s length
2 from each other and clients are instructed to sleep in the bed next to the
3 other person. We have been told that client’s laundry is not collected and
4 they are forced to wash their clothes by hand. They are placed in one room,
5 full of people, some more sick than the other and without any kind of
6 medical oversight or treatment. Clients have reported feeling “ignored”
7 and “forgotten” once sent to “quarantine”. Treatment for those that test
8 positive for COVID-19 is so dire that other detainees, after hearing reports
9 from those that have been “quarantined”, refrain from requesting medical
attention or asking for a test even when experiencing COVID-19 like
symptoms.

10 13. It has been told to AOL Staff, from detainees, that at no point prior, during,
11 or after their COVID-19 test and positive diagnosis, have they received
12 medical attention by a doctor.

13 14. On May 22, 2020 I filed a renewed parole request for a client who has a
14 diagnosis of thyroid cancer; being over the age of 55; heart disease; stage
15 2 hypertension; hypothyroidism and a mental health diagnosis of psychotic
16 disorder with hallucinations. I have not received a response.

17 15. On May 22, 2020 I filed a renewed custody redetermination request for a
18 client who has HIV, Tuberculosis, Hepatitis C, and a thyroid disorder. I
19 have not received a response.

20 16. On May 22, 2020 I filed a renewed custody redetermination request for a
21 client who has asthma and epilepsy. I have not received a response.

22 **Conditions of Detention**

23 17. As of June 2, 2020, our staff have confirmed that people with risk factors
24 at OMDC detention center are not being provided with sufficient room to
25 practice social distancing.

26 18. Clients have reported that they still do not have access to sufficient soap,
27 hand sanitizer or cleaning supplies to wash themselves and their living
28

1 areas. They are given a small “hotel-like” bar of soap that must last them
2 more than a week.

3 19. Clients have reported that they are being confined 22 or 23 hours a day to
4 their cells. Clients have reported that from the one to two hours they are
5 permitted to go outside, they must choose between recreational time or
6 making legal calls. All clients that we have spoken to, including those with
7 depression and mental health disorders, are subject to this confinement.
8 Clients have stated that they are experiencing heightened anxiety and
9 depression from constantly being at risk for catching the virus. They
10 describe nightmares, cold sweats, sadness and further health complications
11 such as high blood pressure and chest pains because of constantly living in
12 fear of catching the virus. On June 2, 2020 one of our clients tried to
commit suicide because of being detained during this epidemic; this client
suffers from Hepatitis C

13 20. We have heard that people are being transferred from U.S. Marshall
14 Detention at OMDC to ICE custody, thereby placing different populations
15 at risk for infection with COVID 19.

16 21. Clients have reported that as of June 2, 2020 staff and detainees are still
17 not wearing cloth or reusable masks. Single use masks must be used for
18 weeks without replacement. When clients have asked for masks they were
19 forced into signing waiver letters absolving OMDC from liability if the
20 client were to get sick. When clients refused, they were retaliated against
21 by being pepper sprayed and by being threatened with solitary
22 confinement. AOL staff has received a copy of this waiver, attached as
Exhibit B, from a client that was detained inside of OMDC.

23 22. Clients have reported that they are not granted free legal calls. They must
24 pay for legal calls. Frequently, if the client has no money, they do not get
25 a legal call. Sometimes, if the client has no money they are given five
26 minute phone calls, which does not allow substantive conversations with
27 legal counsel. The phone calls are sometimes so filled with static that it is
28 difficult to gather facts from the client. When clients pay for their legal
calls, the conversations are recorded and monitored.

1
2 23. We have heard from our clients and volunteers that as of June 2, 2020
3 detained individuals do not have access to gloves. The very infrequent
4 times that we do enter Otay to pick up documents, AOL staff has not
5 observed clients with gloves on. Detained individuals have asked for
6 gloves and have not received them. Importantly, detained individuals at
7 OMDC complete janitorial tasks at Otay Mesa where they are forced to
8 continue this labor in order to get money to afford food and legal calls.
Clients have reported that they complete their janitorial tasks with no
added protection than they had before the COVID-19 outbreak.

9
10 24. We have heard from clients that staff at OMDC wear the same gloves for
11 hours at a time and touch multiple surfaces during this time.

12 25. AOL is aware of dozens of people who are still being detained at OMDC
13 who are elderly or immunocompromised due to diabetes, high blood
14 pressure, and other underlying medical conditions that put them at high
15 risk of contracting and suffering deadly consequences from COVID-19.
OMDC has not released them despite ICE's own directives to release
medically vulnerable people and the elderly.

16
17 26. AOL knows individuals detained at OMDC who are exhibiting symptoms
18 of COVID-19. As of June 2, 2020 detained individuals from OMDC report
19 being sick or witnessing other people with coughs, chills, fevers, and other
20 symptoms and report that they were receiving minimal to no medical
21 treatment. There has been no increase in medical staffing; clients are
seldom, if ever, allowed to see a doctor; and their requests to be evaluated
are almost always ignored.

22 27. Attached as Exhibit C is a declaration from a client currently detained at
23 Otay Mesa describing conditions at the facility. This declaration was filed
24 with an individual habeas petition.

25 28. I, along with the other members at AOL are extremely concerned by ICE's
26 response to the pandemic. We fear for the safety and well-being of the
27 detained individuals at the facilities we serve. We continue to be deeply
28 frustrated and horrified by the lack of efforts ICE and its contractors have

1 made to release vulnerable people and ensure safe conditions for those that
2 remain in their custody. We fear that its actions are putting hundreds of
3 individuals at serious risk of harm or death. One person has already died
4 from COVID-19 at OMDK and it seems as though ICE is encouraging
5 further death.

6 I declare under penalty of perjury and under the laws of the United States, pursuant
7 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
8 knowledge, memory, and belief.

9 Executed on the June 17, in the year 2020, in the city of San Diego, CA.

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Anne M. Rios, Esq.
Al Otro Lado

Exhibit A

Office of Enforcement and Removal Operations

U.S. Department of Homeland Security
Otay Mesa Detention Center
7488 Calzada De La Fuente
San Diego, CA 92154



U.S. Immigration
and Customs
Enforcement

June 12, 2020

Anne Rios, Esq.
Al Otro Lado.
Phone: (619) 821-5340
Email: anne@alotrolado.org
RE: Application for Discretionary Release for

Dear Ms. Rios,

This letter is in reference to the Application for Discretionary Release under *Frailhat v. ICE*, Case No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Apr. 20, 2020), which you filed on behalf of your client on May 21, 2020.

After careful consideration of all of the factors addressed in your request for Application for Discretionary Release and a careful review of your clients administrative file, it has been determined that the granting of such discretionary release is not warranted in this case, as the granting of such discretionary release would not conform to this agency's priority. Therefore, your application for discretionary release is denied. There is no appeal from this decision.

Sincerely,

Mario J. Ortiz

Mario Ortiz
Assistant Field Office Director

Exhibit B



INMATE/DETAINEE/RESIDENT ACKNOWLEDGEMENT and RELEASE – USE OF FACIAL MASK

Date: _____ ID: _____

Name: _____

Institution Location: _____

I acknowledge that I have voluntarily chosen to wear personal protection equipment in the form of a facial mask. I understand and acknowledge that the face mask was issued by CoreCivic and I am not required by CoreCivic to wear the personal face mask, but rather I voluntarily choose to wear the face mask. I understand that a face mask does not provide complete protection from exposure to COVID19, and may not prevent contracting the illness when worn.

I understand and agree to release and hold CoreCivic and its agents and employees harmless from any and all claims that I may have related directly to my wearing the face mask.

I understand and agree that I must fully complete and sign this form in order to be permitted to wear a face mask on the premises of CoreCivic. I understand that I may not adorn my mask with drawings, writings, or other alterations, as that may perforate the mask or otherwise compromise its integrity.

I understand that I am responsible for continuing to adhere to other CDC issued guidelines to prevent the spread of COVID19, including frequent hand washing, social distancing as much as possible, and avoiding skin to skin contact with others.

I understand and agree that the permission to wear a face mask will remain in effect until the Executive Order in my state, declaring a COVID-19 State of Emergency is revoked, and I understand the permission may be revoked at the discretion of CoreCivic, if it is determined to be necessary to comply with applicable state or federal Orders, partner directives, or necessary to ensure the orderly operation of CoreCivic's institutions or promote the health and safety of inmates and staff.

Signature: _____ Date: _____

Staff Witness: _____ Date: _____

Exhibit C

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ANA CECILIA CANDRAY-DE TOBAR

11
12 UNITED STATES DISTRICT COURT
13 SOUTHERN DISTRICT OF CALIFORNIA
14

15 ANA CECILIA CANDRAY-DE
16 TOBAR,

17 Petitioner,

18 v.

19 WILLIAM BARR, United States
Attorney General; CHAD T. WOLF,
20 Acting Secretary of Homeland Security
United States Attorney General;
21 MATTHEW T. ALBENCE, Deputy
Director and Senior Official Performing
Duties of the Director of U.S.
22 Immigration and Customs Enforcement;
GREGORY J. ARCHAMBEAULT, San
23 Diego Field Office Director, Immigration
and Customs Enforcement; JAMES
24 DOBSON, Otay Mesa Detention Center
Officer in Charge, Immigration and
25 Customs Enforcement; CHRISTOPHER
J. LAROSE, Senior Warden, Otay Mesa
26 Detention Center,

27 Respondents.
28

Case No. '20CV0997 DMS JLB

**DECLARATION OF ANA CECILIA
CANDRAY-DE TOBAR**

OTAY MESA COVID-19

ANA CECILIA CANDRAY-DE TOBAR

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3 1. I, Ana Cecilia Candray-De Tobar, was born on April 25, 1966. I am 54
4 years old and a citizen of Guatemala.

5 2. My case is currently before the Immigration Judge. My next hearing is
6 scheduled for June 23, 2020. I have applied for asylum and withholding of removal.
7 I do not have legal representation in my merits case.

8 3. I have been detained at Otay Mesa Detention Center for approximately
9 10 months in total. I was detained on or about June 28, 2019 after I presented
10 myself at the Calexico Port of Entry.

11 4. I suffer from several health conditions that affect my daily life. I have
12 been diagnosed with high cholesterol, elevated thyroid, anxiety, depression, and
13 neurosis. I also suffer from severe allergies and body aches. I have been prescribed
14 and am currently taking Levothyroxine to treat my thyroid condition and
15 Hydroxyzine for my anxiety disorder. I had been prescribed medication for high
16 cholesterol but, for reasons unknown to me, I am not receiving it anymore in the
17 facility.

18 5. It is hard for me to recall exact dates, but I believe that, approximately
19 five weeks ago, the staff in the facility began using masks and gloves for the first
20 time. Before that, they were not using any protective equipment whatsoever.

21 6. Approximately five weeks ago, the detention center staff provided the
22 detainees with general information about COVID-19. I was advised that COVID-19
23 causes symptoms such as fever, stomachache, headaches, and chest pain, and I was
24 instructed to notify personnel should I develop any symptoms. I have also been
25 advised to wash my hands often and for 20 seconds, take more showers, and
26 practice social distancing. Mainly, they advise us to practice social distancing, but
27 due to the nature of the detention center, it has proven to be extremely difficult.
28 Most dormitories have eight (8) beds, literally two steps away from each other,

1 making it impossible to maintain a safe distance from each other.

2 7. I was able to see a doctor on April 26, 2020 because I was suffering
3 from a cough and sore throat. That same day, I was tested for COVID-19 and,
4 approximately six days after the test, I received my results which came back
5 negative. However, the facility's nurse told us that testing negative did not mean
6 that we did not have COVID-19 or that we would not be able to get it in the future.
7 People are still falling ill in my pod. As recent as one week ago , a woman was
8 removed from my pod because of COVID-19, she was bleeding from her nose and
9 they took her away.

10 8. We have not been provided with hand sanitizer, gloves or other
11 protective equipment. I do not have access to tissues, cloths or handkerchiefs.
12 Neither do the rest of the women in my pod.

13 9. There are two cans inside each dormitory. The trashcans do not have
14 lids; therefore, we don't have to touch it to put the garbage inside. However, since
15 we are all assigned to clean our rooms on rotation, the women in my pod and I have
16 to take out the garbage can with our bare hands. The garbage spills because it has
17 no lid.

18 10. In our pod, the other detainees and I have been instructed to clean our
19 dormitories and have been supplied with cleaning products. We are not getting paid
20 to clean our dormitories, it is considered part of our obligations inside the facility.
21 Inside each dormitory, each person is assigned to clean the room one day, on
22 rotation. Due to the lack of gloves or any other protective equipment, my hands
23 have been burned by the chemicals contained in the disinfectants. I have also
24 recently developed a fungus in my finger that has caused my nail to rise and
25 become separated from my finger. I have received medical attention for my nail,
26 but it has not improved.

27 11. My allergies have also been severely aggravated by the cleaning
28 supplies. I am allergic to fumes, disinfectant sprays, aerosols, and dust. When I

1 become in contact with them, which is every day, I begin sneezing nonstop and in
2 some cases the allergy spreads to my throat and makes me cough. On some
3 occasions, it has gotten to the point where it feels like asthma. It has caused me to
4 need allergy medication on a daily basis, which the facility provides me with.
5 Because I am always cleaning, my symptoms do not improve.

6 12. I am assigned to janitorial work in the detention center for which I am
7 paid one dollar a day. I am in charge of cleaning air conditioners, lamps, and
8 bathrooms, amongst others. My job requires me to enter all rooms in my pod to
9 clean them, including the rooms of detainees that have later tested positive for
10 COVID-19. Because I am extremely exposed in my duties at the detention center, I
11 am considering withdrawing from my job in order to protect myself from COVID-
12 19. I have not yet resigned to my duties because I need the money to pay for items
13 in the commissary and phone calls, including calls to lawyers.

14 13. Since the beginning of the pandemic, I have lived in continued and
15 extreme fear of falling ill which causes me to shake uncontrollably and lose sleep.
16 My diagnoses of anxiety and depression have been exacerbated by the stress of the
17 pandemic and the lack of resources in the detention center. As a consequence, I am
18 constantly tense and anxious and have suffered from several panic attacks and night
19 terrors which cause me to scream uncontrollably.

20 14. On various occasions, myself and other women in my pod have
21 organized to demand protective equipment, access to testing, and medical attention.
22 Approximately five weeks ago, on or about, April 10th 2020, we were offered
23 protective masks on the condition that we signed a waiver of liability that released
24 the center from responsibility should we fall ill. Because we refused to sign the
25 waiver, we were not provided with protective masks on that day. At no point before
26 that event we were provided with masks. It was not until April 27, over two weeks
27 after I had refused to sign the waiver, that I received my first mask. The mask was
28 very thin and light blue. They gave me only one mask and I was told that she

1 should re-use it for fifteen days straight. They did not give me any directions as to
2 how to use the mask, clean it, or disinfect it. Nothing at all, only that it should last
3 me for fifteen days.

4 15. When we organized for the first time to demand PPE and refused to
5 sign the waiver, I was told that they would take me to “the hole”, solitary
6 confinement, if I continued. However, because I went inside my dormitory I was
7 not taken to solitary.

8 16. When we refused to sign the waiver in order to receive PPE, we were
9 threatened with pepper spray. The officers sprayed the pepper spray into the air.
10 When they did that, I was headed to my room and it became hard to breathe.

11 17. On or about April 10th, when we demanded personal protective
12 equipment (PPE) and refused to sign a waiver in order to receive it, three women
13 who refused to sign the waiver, were taken to “the hole”. We organized a hunger
14 strike to force the captain to release them. We organized the hunger strike for the
15 release of the women, and we succeeded. Every single one of the women in my
16 unit participated in the hunger strike.

17 18. During our hunger strike, the captain came and told us we had to eat
18 but we refused. She threatened to take us to “the hole” if we didn’t eat. Because
19 some of the women had called humanitarian organizations and the press, such as
20 Telemundo, was covering the events, the staff was forced to release the women
21 from “the hole” that same day. After the women were released, we stopped our
22 hunger strike and were left alone. However, because we did not sign the waiver,
23 we were not provided with masks at that point.

24 19. The staff’s treatment towards me has changed since I refused to sign
25 the waiver over a month ago. On some occasions, I have solely received bread and
26 water or plain milk instead of a meal. They have not provided us with our regular
27 diets, which in cases such as mine, is ordered by the doctor due to my high
28 cholesterol condition. The staff’s attitude towards me has also changed. After the

1 waiver event, the staff does not acknowledge me anymore and if I complain about
2 anything, they completely ignore me. On one occasion, my documents got lost or
3 stolen and when I went to the officer, the officer informed me that there was
4 nothing she could do and refused to help me.

5 20. Prior to April 27, 2020, I had requested protective equipment along
6 with others in my pod but was not provided with any. Since I lacked any protective
7 equipment, I made my own mask by cutting and tying one of my shirts. However,
8 when staff noticed, they threatened that I would be charged for the shirt, because I
9 had damaged it. I was advised by the staff that I was in “big trouble”. I was
10 prohibited from using my makeshift mask and therefore had no protection at all
11 until I received a mask on April 27, 2020.

12 21. On April 27, 2020, I was given one very thin, light blue face mask,
13 similar to a surgical mask, which I was instructed to reuse for fifteen (15) days
14 straight. I was not instructed in regard to the use, care, and sterilization of the mask.
15 We were not provided reusable cloth masks.

16 22. There used to be about eighty (80) people in my unit but now, there are
17 about sixty (60) people in my unit. I do not know where the women who were here
18 before have gone. Many of them have been taken away because they had COVID
19 symptoms.

20 23. Our dormitories at the facility do not make it possible to practice social
21 distancing because the beds are very close together. Some of the beds have been
22 emptied but, in rooms such as mine, all beds are currently occupied.

23 24. When we used to attend church, the room got very crowded. We sat
24 close to each other and there was not enough space to practice social distancing.
25 We have been prohibited from attending church for about five weeks now.

26 25. Around five weeks ago, there was a young lady in our unit that was
27 very sick and could hardly walk. She got tested for COVID-19 and her results
28 came back positive. She was removed from our pod but, after being gone for eight

1 days, she returned to our unit. However, because she still had symptoms of
2 COVID-19 when she returned, she had to be removed again. When she returned
3 for the first time, nobody went near her because she looked very sick. She was
4 obviously ill.

5 26. Fourteen or Fifteen other women have also tested positive for
6 COVID-19 and have been subsequently removed from our unit. Most of them were
7 brought back to our unit approximately fourteen days after being removed. I was
8 told by other detainees that everyone who tests positive for COVID-19 is placed
9 together in a single room. One of my friends was placed in that room. She
10 explained to me that the room was extremely dirty and was infested with
11 cockroaches.

12 27. At present, nobody is being checked for symptoms at the facility. At
13 some point, the staff took our temperature daily. However, this occurred for one
14 week only and then they stopped. At no point did they ask us if we had any
15 symptoms or if we were feeling ill.

16 28. They started testing people approximately five weeks ago. However,
17 the only people getting tested are the ones who seek medical attention because they
18 already have symptoms. In my case, I developed a bad cough and felt very ill to
19 the point where I could not even speak. I went to the doctor and explained that I
20 had been feeling sick. They performed the COVID-19 test that same day.
21 However, if the person does not feel very ill, they are not getting tested. Many of
22 the persons in my unit have tried to get tested but they have been told that there are
23 not enough tests for everyone.

24 29. Almost all of the women who have tested positive for COVID-19 and
25 thus removed from my unit have now returned. Some of them returned looking
26 sick. One of them is my friend who told me that they were being kept in a dirty
27 room where she got bitten by a cockroach.

28 30. In my unit, we share bathrooms, tables, chairs, telephones, and

1 kitchen. The kitchen is what worries me most because we only have two ovens and
2 everybody touches them, including the women who have tested positive for
3 COVID-19. When we are outside our dormitories, we also share the tables.

4 31. Before the staff at Otay Mesa started wearing mask and gloves, they
5 would touch us without protective equipment to give us documents, papers, or
6 messages.

7 32. I asked the detention center for a humanitarian parole form and filled it
8 out. I just received a notification that my parole was denied because, apparently, I
9 am missing some documents. The letter was in English and I do not understand it
10 but a detainee that read it for me told me that some documents were missing. I have
11 not had an attorney to help me with parole and it costs money every time I call out
12 to try to obtain legal help. I am not sure why the facility is making us pay for legal
13 calls.

14 33. I have a sponsor that completed a declaration in support of my parole
15 request. If I were to leave the detention center, I ensure that I will quarantine upon
16 release at my sponsor's home.

17 34. I don't have a criminal history. I have never been arrested, charged
18 with a crime or sentenced. I have never been in prison or jail.

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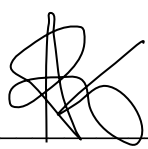
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CERTIFICATION

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Because of the coronavirus, and my confinement in the Otay Mesa Detention Center, I was not able to sign this declaration in person. The declaration was read to me in Spanish, a language I understand, by Adriana Rivero on May 26, 2020. I understood and verified its contents in full, and authorized Adriana Rivero to sign the declaration on my behalf.

Executed on May 26, 2020 in San Diego, California.



Adriana Rivero

E-SIGNATURE

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15 **UNITED STATES DISTRICT COURT**
16 **CENTRAL DISTRICT OF CALIFORNIA**
17 **EASTERN DIVISION – RIVERSIDE**

18 FAOUR ABDALLAH FRAIHAT, *et al.*,
19 Plaintiffs,
20 v.

21 U.S. IMMIGRATION AND CUSTOMS
22 ENFORCEMENT, *et al.*,
23 Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

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26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF WILLIAM LIENHARD

I, William Lienhard, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

1. I am a lawyer admitted to practice in the State of New York.
2. I am familiar with the *Fraihat* subclasses pursuant to the April 20, 2020 preliminary injunction order.
3. I recently represented two detainees *pro bono* who qualify as *Fraihat* subclass members on requests for review of their custody pursuant to the *Fraihat* order: 1) Neil Brian Zavala Polanco, Alien Number 092099852 and 2) Gavril Hojda, Alien Number 215555921.
4. As explained in greater detail below, based on my experience representing Mr. Polanco and Mr. Hojda, I have concerns about whether Immigration and Customs Enforcement (ICE) is protecting detainees from COVID-19 and how ICE is implementing the *Fraihat* preliminary injunction.

Custody Redetermination Request for Neil Brian Zavala Polanco

5. Mr. Polanco is 46 years old. His parents brought him to the United States when he was three months old, and he became a legal permanent resident at the age of 12. He is currently detained at Adelanto Detention Center.
6. I recently prepared a *Fraihat* request for Mr. Polanco, who is a member of both *Fraihat* Subclasses One and Two. Mr. Polanco has Type II diabetes, bipolar disorder, high blood pressure, high cholesterol, and a damaged lung. Prior to his detention, he received Supplemental Security Income (SSI) due to his disabilities.
7. I submitted Mr. Polanco's *Fraihat* request on June 17. It is still pending.
8. In a follow-up conversation that I had with Mr. Polanco after submitting his *Fraihat* request, Mr. Polanco told me about some alarming conditions at Adelanto. Mr. Polanco said that he is detained within a special segregated unit at Adelanto for people with severe mental illness.

- 1 9. Since mid-March 2020, ICE has used Mr. Polanco's unit at Adelanto to
2 "quarantine" newly detained men.
- 3 10. Mr. Polanco reports that these new people are coming from intake, and not
4 from another ICE facility, because they arrive with their belongings in
5 laundry bags, and not in the garbage bags that ICE uses when it moves
6 detainees from one facility to another.
- 7 11. ICE brings a group of 10-12 men into the unit and puts them on "lockdown"
8 for 14 days. This means that they are locked in their cells except for about an
9 hour and a half of free time each day.
- 10 12. After 14 days, ICE cycles the new detainees on to other detention facilities
11 so that it can move another group of 10-12 men into the unit.
- 12 13. During their free time, the new detainees socialize in the day room, an area
13 in the center of two tiers of cells, sit at one of the four lunch tables, or use
14 one of the four showers in the unit.
- 15 14. While the new detainees are out of their cells, the long-term detainees like
16 Mr. Polanco are locked in. But there is a gap between the cell doors and the
17 floor, so the new detainees and the long-term detainees can converse.
- 18 15. The new detainees have consistently reported to Mr. Polanco that ICE has
19 not tested them for COVID-19 before placing them in the unit. Mr. Polanco
20 is very concerned because the air circulates freely throughout the unit.
- 21 16. Adelanto does not require the new detainees to wear masks or to observe
22 social distancing. Adelanto staff does not disinfect the showers, the lunch
23 tables, or other areas after the new detainees use them.
- 24 17. Instead of quarantining these new groups of detainees, ICE is moving them
25 into a densely-populated unit without making any effort to prevent the
26 transmission of COVID-19 from the new detainees to the long-term
27 detainees (or vice-versa).
- 28 18. ICE's decision to use Mr. Polanco's unit as a holding tank for new detainees
is putting the health of Mr. Polanco and the other detainees in the unit at
risk.

Custody Redetermination Request for Gavrilă Hojda

19. Mr. Hojda was detained post-removal at Etowah Detention Center. He was convicted *in absentia* of a crime in Romania, his native country, and if deported there, he would be imprisoned. When I began working with him, Mr. Hojda had been detained at Etowah since August 2019.

20. On May 21, Mr. Hojda described a number of health conditions which put him at higher risk for contracting and suffering serious harm from COVID-19, including: high blood pressure, a persistent dry cough, sharp chest pains, severe pain in his neck, low back, and legs, and high cholesterol.

21. ICE gave Mr. Hojda medication for his high blood pressure and cholesterol, and an ineffective waistband brace for his low back.

22. Mr. Hojda reported that since March, detainees at Etowah had been locked in their cells except for one hour in the morning, an hour and a half at lunch, and two hours at dinner.

23. I asked Mr. Hojda if we could set up a regular time for him to call me from the phone in his unit so that we would not have to schedule our calls through Captain O'Bryant. Mr. Hojda said this would be nearly impossible because he was usually locked in his cell.

24. Mr. Hojda was extremely distressed throughout our call, and at one point burst into tears and sobbed speechlessly.

25. After the call, at 1 p.m. on May 21, 2020, I emailed Captain O'Bryant to thank him for setting up the call and to schedule a future call for May 29 at 12 p.m. At 1:47 p.m. that same day, Captain O'Bryant replied "No problem."

26. Later in the day on the 21st, though, I learned that ICE had just closed the account where ICE allowed Mr. Hojda to keep funds for use in the commissary. Since this can indicate that ICE is about to transfer a detainee, I

1 emailed Captain O'Bryant at 10:24 p.m. and asked whether ICE was
2 transferring Mr. Hojda, and if so, where. The following day, May 22, Captain
3 O'Bryant emailed me to say that "immigration did move him today" and that
4 I should call Scot Pitman at 256-543-8154 to find out where. I was surprised
5 to hear this; at no point in our correspondence on May 21 did Captain
6 O'Bryant mention that Mr. Hojda was about to be transferred, even though
7 he had scheduled a future call with Mr. Hojda for May 29.

7 27. When I called Scot Pitman, he told me that ICE was transferring Mr. Hojda
8 to Alexandria Staging Facility in Louisiana, and then to Oakdale Detention
9 Center. That same day, May 22, I emailed a *Fraihat* request for Mr. Hojda to
10 Robert Hagan, AFOD at ICE, and Diana Witte, Interim New Orleans Field
11 Office Director.

12 28. On May 26, 2020 at 10:51 a.m., Bryan S. Pitman (who may or may not be
13 the same person as Scot Pitman) sent me the following email denying the
14 May 22 *Fraihat* request:

15 "Regarding A 215 555 921 HOJDA, ICE identified Mr. Hojda's case as
16 meeting the criteria for *Fraihat* and in April 2020, conducted a custody
17 review to determine whether continued detention remains appropriate in
18 light of the COVID-19 pandemic. ICE continues to evaluate cases for
19 custody in association with current detention conditions. We reviewed Mr.
20 Hojda's case and based on the relevant factors, determined that continued
21 detention remains appropriate."

22 29. I replied at 1:56 p.m. and asked for information and records concerning the
23 April 2020 *Fraihat* review and the decision to deny Mr. Hojda's May 22
24 *Fraihat* request.

25 30. Mr. Pitman replied at 2:41 p.m. that "Mr. Hojda was released from
26 ICE/ERO custody today for removal to Romania via special charter."
27
28

1 31. I was surprised to learn this. Mr. Pitman had not mentioned an impending
2 deportation in his 10:51 a.m. email, sent only four hours earlier. Nor had
3 anyone else at ICE notified me that ICE was about to deport Mr. Hojda.

4 32. I sent a follow-up email to Mr. Pitman, and asked where Mr. Hojda was,
5 how I could contact him, whether ICE had deported him, what steps ICE
6 took to protect him from COVID-19 during transport, and what research ICE
7 did to determine whether Mr. Hojda risks contracting COVID-19 in the
8 Romanian prison system. To date, I have received no response to any of
9 these questions.

10 33. I later learned that Mr. Hojda was deported to Romania after being detained
11 for over 8 months.

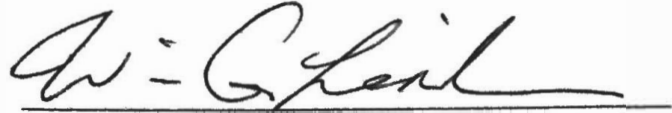
12 34. Following Mr. Hojda's deportation, I continued to email Mr. Pitman to ask
13 for information and records related to the two *Fraihat* reviews ICE allegedly
14 performed and concerning my client's deportation to Romania. Mr. Pitman
15 would not provide any information or records, and cc'd William Lund,
16 Senior Attorney, Office of the Principal Legal Advisor, ICE.

17 35. I spoke with Mr. Lund on the phone on June 9, 2020. Mr. Lund said that
18 ICE is not obligated to justify the decisions it makes after custody reviews
19 performed pursuant to *Fraihat* or to provide documentation or explain its
20 process. According to Mr. Lund, *Fraihat* merely requires ICE to perform the
21 reviews, and nothing more. Mr. Lund also said that *Fraihat* does not entitle
22 detainees to any information or records related to ICE's decisions to grant or
23 deny their *Fraihat* requests.

24 36. To date, despite my requests, I not received any records or information
25 concerning 1) ICE's decision to keep Mr. Hojda in custody in April 2020
26 after its first alleged *Fraihat* review or 2) ICE's decision to deny the *Fraihat*
27 request I submitted on May 22, 2020.

28 I declare under penalty of perjury and under the laws of the United States, pursuant
to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
knowledge, memory, and belief.

Executed on June 22, 2020 in the city of Grantham, NH.

A handwritten signature in black ink, appearing to read "W. Lienhard", written over a horizontal line.

William Lienhard, Esq.

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15 **UNITED STATES DISTRICT COURT**
16 **CENTRAL DISTRICT OF CALIFORNIA**
17 **EASTERN DIVISION – RIVERSIDE**

18 FAOUR ABDALLAH FRAIHAT, *et al.*,
19 Plaintiffs,
20 v.
21 U.S. IMMIGRATION AND CUSTOMS
22 ENFORCEMENT, *et al.*,
23 Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF CHARLIE
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26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF CHARLIE FLEWELLING

I, Charlie Flewelling, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Charlie Flewelling. I serve as staff attorney at Santa Fe Dreamers Project. Santa Fe Dreamers Project provides free legal representation on immigration matters to clients in Albuquerque and Santa Fe, and through our rural legal clinics in Taos and Valencia Counties in partnership with local agencies and community organizers. My initial role was to provide support and legal representation for those detained individuals in the transgender pod at the Cibola County Detention Center.
2. Since the Cibola transgender pod closed in January 2020 I have focused on providing remote legal assistance to LGBTQI/HIV+ migrants in ICE detention in a variety of facilities including Winn Correctional Center, Aurora ICE Processing Center; Nevada Southern Detention Center (Nevada Southern), Otero County Processing Center, and El Paso Service Processing Center.
3. Since the outbreak of the COVID-19 pandemic, I have been in continuous contact with detained individuals at Nevada Southern.
4. I have been in communication with clients at Nevada Southern by phone.
5. I am familiar with the *Fraihat* subclasses pursuant to the April 20, 2020 order.

Communication Access at Nevada Southern Detention Center

6. In the course of communicating with clients at Nevada Southern I have had difficulty reaching clients held on units F4 and F2; sometimes scheduled calls are not made, and when the calls have been connected they have been from the office of a unit counselor who remained present with my client for the duration of the call.

7. At various times I have been told that the phone for legal calls was broken and that IT would fix it, that the phone for legal calls had been taken to another unit, and that the phone was never actually for legal calls - rather it was to call staff at Nevada Southern.
8. When clients requested they be allowed to make calls about their representation away from unit staff the only option offered is collect calls. The collect calls, made through IC Solutions, cost money and are recorded by a private third party, therefore they cannot be considered confidential.
9. In the midst of the pandemic, where in-person client visits at Nevada Southern are not currently allowed, limitations on telephonic communications hinder effective advocacy.

Custody Redetermination Requests

10. Based on Santa Fe Dreamers Project knowledge and understanding, ICE is not conducting individualized custody determination requests pursuant to the April 20, 2020 Court order.
11. As of June 11, 2020 our staff have filed custody redetermination requests for three transgender individuals who are each HIV+ at Nevada Southern.
12. I sent separate *Frailhat* based custody redetermination requests to DOs in the Las Vegas Field Office on May 11, 12, and 19, 2020.
13. On May 12, I received emails from Las Vegas SDDO Kevin Speese informing me that on April 15 custody redeterminations had already been made for both clients for whom I had submitted *Frailhat* custody redetermination requests.
14. On May 12, I replied that my clients had submitted new sponsor information that potentially had not been considered, and that the *Frailhat* order was made April 20, 2020 and therefore my clients requests for custody redetermination must be considered.

15. On May 15, I followed up with SSDO Speese asking for an update given that ICE had just confirmed the first COVID-19 case at Nevada Southern.
16. On Saturday, May 16, SSDO Speese directed me to SSDO Cantrell as SSDO Speese was no longer working detention.
17. On May 19, after I inquired again regarding the custody redetermination requests, SSDO Cantrell emailed that requests were being considered by upper management and that he was hopeful the decision would be made by the end of the week.
18. On May 27, I emailed SSDO Cantrell with letters regarding all three custody redetermination requests, including individualized letters for each asking what procedures were being used to evaluate my clients and who was making the evaluations.
19. On June 1, I received three undated letters from Salt Lake City AFOD Tracey Cammorto denying each reconsideration request that I made.
20. The identical denials from AFOD Cammorto state that custody redeterminations were conducted pursuant to *Frailhat*, and that a thorough review of all evidence submitted and surrounding factors was conducted. The denials provide no information as to what documents were reviewed, the qualifications of the evaluators, or the reasons for the denials.
21. All three requests were made based on the clients' positive HIV statuses. The decisions took 21, 20, and 13 days respectively. One of my clients has no known criminal history in any country. All three of my clients have sponsors ready to take them in, including two clients with family sponsors.

Conditions of Detention

22. I spoke with multiple clients at Nevada Southern on June 2, 8, and 9, 2020. I confirmed that people with risk factors at Nevada Southern are not being provided with sufficient room to practice social distancing. The population

in dorm F4 housing two of my transgender clients with cisgender men has grown over the last month and stood at 57 as of June 9. Clients report that the bottom of each of the 48 bunk beds is full and that some of the top bunks are also in use. I understand that this is the result of continuing transfers, the latest coming in yesterday, June 8, 2020.

23. Clients reported that the liquid soap dispenser, that was installed in the bathroom for dorm 4F during the pandemic, broke on or about May 30. Small free white bars of soap were the only soap option. The liquid soap dispenser was replaced on or about June 6.
24. Clients continue to report disruptions to receiving their medications. One client told me she had recently missed one week of prescribed hormones.
25. Clients report hearing Nevada Southern staff complaining about being short-staffed and needing to work overtime because of staff shortages. On Sunday, May 31, clients reported not getting their medication, including HIV medication, at night because nurses were unavailable to bring medication to the dorm.
26. Clients report that medications are distributed at irregular times. When pill call is made detainees congregate where the nurse is. The nightly pill call is generally made between 8:00 PM and 12:00 AM, with reports of pill call being made as late as 2:00 AM. When a client missed a particularly late call there was no effort made to wake her up. The next day nurses refused giving my client an extra dose of her medication and told her that getting to pill call was her responsibility.
27. Clients report that staff at Nevada Southern are wearing masks but not gloves. Clients report that guards and medical staff take masks off to hold conversations with each other and with detainees.
28. Clients also report that detainees are not wearing their cloth masks that detainees were given which were distributed in mid-April.
29. Santa Fe Dreamers Project is aware of three transgender people who are still being detained at Nevada Southern who are elderly or immunocompromised

due to diabetes, high blood pressure, and other underlying medical conditions that put them at high risk of contracting and suffering deadly consequences from COVID-19. Nevada Southern has not released them.

30. I, along with the other members at Santa Fe Dreamers Project, are extremely concerned by ICE's response to the pandemic. We fear for the safety and well-being of the detained individuals at the facilities we serve. We continue to be deeply frustrated and horrified by the lack of efforts ICE and its contractors have made to release vulnerable people and ensure safe conditions for those that remain in their custody. We fear that its actions are putting hundreds of individuals at serious risk of harm or death.

I declare under penalty of perjury and under the laws of the United States, pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the June 11, in the year 2020, in Albuquerque, NM.



Recoverable Signature

X

Charlie Flewelling

Charlie Flewelling

Signed by: b6bddc5e-cc4d-401c-b336-6735f8a87269

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF CRAIG
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**Pro Hac Vice Application Forthcoming

DECLARATION OF DR. CRAIG W. HANEY, PH.D.

I, Craig W. Haney, declare as follows:

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

2. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations). In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate in a hearing that focused on the use and effects of solitary confinement and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. My research, writing, and testimony have been cited by state courts, including the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the

1 United States Supreme Court.¹ A copy of my curriculum vitae is attached to this
2 Declaration as Exhibit A.

3 3. I have been asked by plaintiffs' counsel in *Fraihat v. ICE*, who represent
4 medically vulnerable people and people with disabilities throughout ICE's
5 detention system to opine about the likely psychological impact of practices,
6 procedures, and conditions that have been implemented by ICE and its contractors
7 to respond to the COVID-19 Pandemic and to recommend appropriate responses to
8 the crisis.

9 4. I have been provided with an extensive number of documents to review and
10 on which I have relied in the preparation of this Declaration. A list of documents I
11 have reviewed is attached to this Declaration as Exhibit B.

12 5. It is my expert opinion that:

13
14 A. Consistent with the Court's Preliminary Injunction Order in this case, the
15 evidence increasingly demonstrates that psychiatric disability is a risk factor
16 for serious complications or death from COVID-19;

17 B. The practice in ICE detention centers of locking people in conditions that
18 are the equivalent to punitive solitary confinement cells, defined and
19 discussed below, as a form of "quarantine" or "medical isolation," or as an
20 attempt to reduce the spread of the pandemic, is inappropriate because it
21 places them at heightened risk of severe psychological harm;

22 C. ICE detainees with pre-existing mental illness or emotional impairment²
23 are especially at risk in the course of the COVID-19 pandemic, in part

24
25 ¹ For example, see *Brown v. Plata*, 563 U.S. 493 (2011).

26 ² In this Declaration, I use the broader definition of "mental illness" taken from the
27 Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act. Under
28 this act, an "individual with a mental illness" is an individual "who has a
significant mental illness or emotional impairment, as determined by a mental

1 because they are less able to reliably identify and report symptoms and to
2 engage in necessary forms of self-protection and self-care, and for these
3 reasons require especially careful and conscientious medical monitoring;

4 D. ICE detainees with pre-existing mental illness or emotional impairment
5 are especially likely to suffer an exacerbation of their psychiatric disability if
6 they are placed in conditions that are the equivalent of solitary confinement
7 (where they are known to be at heightened risk) which, in turn, makes them
8 even more medically and psychologically vulnerable;

9 E. The fact that the disability of having a pre-existing mental illness or
10 emotional impairment is not necessarily a static condition but rather may
11 emerge more clearly over time or be exacerbated by especially stressful
12 conditions (such as those associated with a threatening pandemic)
13 underscores the need for periodic reassessments to determine potentially
14 changed conditions;

15 F. Placing ICE detainees (including those who are mentally ill or
16 emotionally impaired) in conditions that are the equivalent of solitary
17 confinement in lieu of appropriate forms of medical isolation is likely to
18 deter them from reporting their symptoms (to avoid such onerous
19 conditions) and unintentionally contribute to the spread of the virus.

20 G. The practice in ICE detention centers of locking people into their cells in
21 dorm housing as a form of “quarantine” or “medical isolation,” or as an
22

23

health professional qualified under the laws and regulations of the State....” 42
24 U.S.C. § 10802(4)(A). “Significant mental illness” and “emotional impairment”
25 are not further defined in the PAIMI Act or its implementing regulations.
26 However, courts have generally favored a broad definition of these terms. *See*
27 *Connecticut Office of Prot. & Advocacy for Persons with Disabilities v. Hartford*
28 *Bd. of Educ.*, 355 F. Supp.2d 649, 655 (D. Conn. 2005), *aff’d*, 464 F.3d 229 (2d
Cir. 2006).

1 attempt to prevent the spread of the pandemic, is inappropriate and
2 potentially harmful because it consists of punitive forms of social and
3 material deprivation that are not consistent with proper medical quarantine
4 and isolation practices, where patients are administered to by medical rather
5 than security staff and are given access to enhanced activities and outlets
6 (e.g., television, commissary, free phone calls).

7 Background Information

8
9 6. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is
10 no cure for COVID-19. No one has immunity. Currently, the most effective ways
11 to control the virus are to use preventive strategies, including social distancing, in
12 order to maximize our healthcare capacity for a manageable number of patients.
13 Otherwise, healthcare resources will be overwhelmed, and the Pandemic will
14 worsen.

15 7. Persons with mental health-related issues—those who are diagnosed as
16 mentally ill or those with sub-clinical symptoms such as depression or anxiety—
17 are especially vulnerable in the Pandemic. Because there is as yet no vaccine, cure,
18 or immunity, controlling the virus through preventive strategies depends heavily of
19 various forms of self-care, including maintaining social distancing, taking personal
20 sanitary precautions, and the like. These strategies are especially difficult for
21 psychiatrically vulnerable persons to initiate and consistently maintain. Some
22 detainees with mental health problems may resist wearing masks because they do
23 not fully understand the reasons for doing so. Others may be frightened by being
24 surrounded by mask-wearing staff and detainees. They need special attention and
25 treatment in order to address these anxieties and allay their fears. Finally, mentally
26 ill and psychiatrically vulnerable detainees are more likely to be adversely affected
27 by the anxieties and uncertainties that are associated with the risk of being infected
28 by a potentially deadly virus.

1 8. From a psychological perspective, ICE's April 28, 2020 list of mental health
2 diagnoses meant to trigger a reassessment and review is inadequate. That list
3 currently includes "Psychotic Disorder; Bipolar Disorder; Schizophrenia or
4 Schizoaffective Disorder; Major Depressive Disorder with Psychotic Features;
5 Dementia and/or a Neurocognitive Disorder; Intellectual Development Disorder
6 (moderate, severe or profound)." Mental health conditions and subclinical
7 diagnoses (including emotional impairments that are considerably less severe than
8 ICE's listed diagnoses) can also lead to being psychologically vulnerable to
9 COVID-19.

10 9. Social distancing presents serious practical and physical challenges for
11 everyone in every part of our society, but nowhere more than in congregate
12 detention centers, such as ICE detention. Like penal institutions in general, the
13 living conditions in these facilities are unusually sparse and detainees necessarily
14 live in unescapably close quarters with one another.

15 10. Moreover, ICE detention centers, like jails and prisons, are already
16 extremely stressful environments for the persons confined in them.³ They can be
17 psychologically and medically harmful in their own right, rendering persons who
18 are exposed to them unusually vulnerable to stress-related and communicable
19

20
21 ³ Much of this evidence is summarized in several book-length treatments of the
22 topic. For example, see: Haney, C., *Reforming punishment: Psychological limits to*
23 *the pains of imprisonment*. Washington, DC: American Psychological Association
24 (2006); Liebling, A., & Maruna, S. (Eds.), *The effects of imprisonment*.
25 Cullompton, UK: Willan (2005); and National Research Council (2014). *The*
26 *Growth of Incarceration in the United States: Exploring the Causes and*
27 *Consequences*. Washington, DC: The National Academies Press. In addition, there
28 are numerous empirical studies and published reviews of the available literature.
For example, see: Haney, C., Prison effects in the age of mass incarceration.
Prison Journal, 92, 1-24 (2012); Johns, D., Confronting the disabling effects of
imprisonment: Toward prehabilitation. *Social Justice*, 45(1), 27-55.

1 diseases.⁴ Incarceration leads to higher rates of morbidity (illness rates) and
2 mortality (i.e., it lowers the age at which people die).⁵ The stresses of COVID-19
3 substantially exacerbate these already high-stress environments, and ICE must do
4 what it can to abate these psychological stressors given the possibility that they
5 will cause or worsen people's mental illness.

6 11. Most ICE detention facilities already operated at or beyond the limits of
7 their capacities to provide effective mental health care long before the COVID-19
8 Pandemic began. For example, a 2019 report by Disability Rights California about
9 Adelanto Detention Center in California noted the harsh conditions of solitary
10 confinement at that facility, their widespread use of solitary confinement in lieu of
11 proper mental health treatment, and the disproportionate harm such practices
12 visited on people with mental health disabilities.⁶ A 2011 report by the Department
13

14 ⁴ As one index of the lasting effects of the stressfulness of this kind of
15 confinement, we know that formerly incarcerated persons suffer higher rates of
16 certain kinds of psychiatric and medical problems. *E.g., see:* Schnittaker, J. (2014).
17 The psychological dimensions and the social consequences of incarceration.
18 *Annals of the American Association of Political and Social Science*, 651, 122-138;
19 Turney, K., Wildeman, C., & Schnittker, J., As fathers and felons: Explaining the
20 effects of current and recent incarceration on major depression. *Journal of Health
21 and Social Behaviour*, 53(4), 465-481 (2012). *See, also:* Listwan, S., Colvin, M.,
22 Hanley, D., & Flannery, D., Victimization, social support, and psychological well-
23 being: A study of recently released prisoners. *Criminal Justice and Behavior*,
24 37(10), 1140-1159 (2010).

25 ⁵ *E.g., see:* Binswanger, I., Stern, M., Deyo, R., et al., Release from prison: A high
26 risk of death for former inmates. *New England Journal of Medicine*, 356, 157-165;
27 Massoglia, M. Incarceration as Exposure: The Prison, Infectious Disease, and
28 Other Stress-Related Illnesses. *Journal of Health and Social Behavior*, 49(1), 56-
71; and Massoglia, M., & Remster, B., Linkages Between Incarceration and
Health. *Public Health Reports*, 134(Supplement 1), 85-145 (2019); and Patterson,
E. (2013). The dose-response of time served in prison on mortality: New York
state, 1989-2003. *American Journal of Public Health*, 103(3), 523-528.

⁶ Disability Rights Cal., *There Is No Safety Here*, at 17 (Mar. 2019),
<https://www.disabilityrightsca.org/system/files/file->

1 of Homeland Security Office of Inspector General on Mental Health Management
2 in ICE detention noted that mental health positions were frequently understaffed
3 and that detained people with mental health disabilities who were placed in solitary
4 confinement settings reported increased levels of mental health difficulties.⁷
5 Finally, in 2016, OIG issued another Mental Health Staffing Report, concluding
6 that ICE continued to fail to attract and retain adequate qualified mental health care
7 providers, at least in part due to the rural and remote areas where ICE elected to
8 detain individuals.⁸ It is unlikely that they will be able to rapidly increase their
9 capacity in light of the challenges now faced by mental health and medical
10 professionals in society at large. Thus, the ability of ICE facilities to gain access to
11 higher or more acute levels of psychiatric care in surrounding community
12 hospitals, if and when it is needed, may be extremely limited, especially when
13 existing community resources are already overtaxed by the current Pandemic.

14 12. Because the demand for such services in this crisis will only grow, already
15 scarce treatment resources will be stretched even more. In ICE detention facilities
16 that do not act immediately to reduce their numbers of detainees and instead
17 become places where COVID-19 spreads rapidly throughout, mental health care as
18 well as medical resources may become overburdened in the surrounding
19 communities as well as the facilities themselves.

20
21 [attachments/DRC_REPORT_ADELANTO-](#)
22 [IMMIG_DETENTION_MARCH2019.pdf](#).

23 ⁷ Office of Inspector Gen., Dep't of Homeland Sec., *OIG-11-62: Management of*
24 *Mental Health Cases in Immigration Detention*, at 15 (Mar. 2011),

24 <https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf>

25 ⁸ Office of Inspector Gen., Office of Homeland Sec., *OIG-16-113-VR: ICE Still*
26 *Struggles to Hire and Retain Staff for Mental Health Cases in Immigration*
27 *Detention*, at 2 (July 2016), [https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-](https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VRJul16.pdf)
28 [113-VRJul16.pdf](https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VRJul16.pdf).

Use of Solitary Confinement in ICE Detention as a Response to the Pandemic

13. Quarantines, as the general public well knows by now, are sometimes required to prevent the spread of COVID-19, which is consistent with CDC recommendations. In addition, the CDC recommends the use of medical isolation for people who are positive for COVID-18, including in congregate settings such as ICE detention centers. For example, the CDC recommends:⁹

A. Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine. (p. 19)

B. If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started. (p. 19)

C. If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19. Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.) (p. 20)

D. The CDC does recommend that people who are in quarantine or medical isolation live in a single cell. (pp. 16; 20)

⁹ *Interim Guidance on Mgmt. of Coronavirus Disease 2019 (COVID-19) in Corr. and Det. Facilities*, CDC (Mar. 23, 2020) <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

1
2 E. Crucially, however, the recommendation to quarantine or medically
3 isolation and individual is not the same as placing that person in conditions
4 equivalent to solitary confinement. The goals of quarantining or medically
5 isolating an individual can be met without placing them in dangerous
6 conditions equivalent to solitary confinement.
7

8 14. Unfortunately, in contravention to the recommendations above, it is my
9 understanding from the documents that I have reviewed that the ICE detention
10 facilities have implemented a form of general housing unit “lockdowns” in an
11 attempt to control infection and also solitary-type confinement for some detainees
12 in response to the COVID-19 Pandemic in lieu of appropriate quarantining or
13 medical isolation.

14 15. Further, I have reviewed both the ICE Pandemic Response Requirement
15 (“PRR”) document dated Apr. 10, 2020, and the updated PRR dated June 22, 2020.
16 Both versions include some of the above CDC guidelines. Since the practices I
17 describe violate the CDC guidelines, they also appear to violate ICE’s own PRRs.
18 As a result, detained people are exposed to ongoing risk of harm as described more
19 fully below.

20 16. Many ICE detainees are now confined to their cells for approximately 23
21 hours a day. Some general population living units and dorms house detainees in
22 small spaces. Some of the solitary confinement-like cells (where detainees now
23 sleep, eat, and defecate) are very small. Detainees living under these lockdown-
24 type conditions are typically given very limited out-of-cell time, often only an hour
25 or two, during which they can recreate (in small groups), make any social and legal
26 phone calls, and shower before being returned to their small cells.
27
28

1 17. During this limited out-of-cell time, detainees crowd together to use the
2 limited shared resources. They crowd together in the small area of outdoor space
3 that affords them sunlight, and also when they have access to phones (since this is
4 the only way for them to have immediate contact with the outside world). As a
5 result, they are unable to maintain the recommended six feet of social distancing.
6 Moreover, they are not being provided with adequate face masks, so they are
7 unprotected when they come in such close contact with one another.

8 18. In addition, ICE detention facilities are ill-equipped to provide detainees
9 with ready access to cleaning and sanitation supplies, or to assure that staff sanitize
10 all surfaces during the day. Yet detainees are surrounded by and enveloped in hard
11 metal surfaces, precisely the kind on which the COVID-19 virus lives longest. In
12 addition, detainees are denied access to liquid soap and effective alcohol-based
13 disinfectants and hand sanitizers, which are recommended as effective for use
14 against COVID-19 in free society. This appears to be an even more acute problem
15 in solitary confinement housing than in general population spaces.

16 Examples of Detained People's Experiences

17 19. I reviewed the declarations of detained class members listed in Exhibit B. I
18 also reviewed public reports regarding the death by suicide of a class member and
19 a letter written by the Southern Poverty Law Center on behalf of a class member. I
20 describe the experiences of these detained people below.

21 20. Many of the issues I describe above are illustrated in the Declaration of
22 detainee Ruben Dario Mencias Soto, a 37-year-old man confined in the Adelanto
23 Detention Center. Mr. Soto was taken for emergency treatment for heart-related
24 symptoms that were ignored by ICE staff. When his condition worsened, he was
25 taken to the emergency room of a nearby hospital. After receiving treatment at the
26 hospital for several days, he was returned to Adelanto but was taken to a dorm that
27 is ordinarily used for punishment, referred to as "the Hole" by detainees. He
28

1 reported that he is locked in a cell by himself for approximately 23 hours a day,
2 with only a single hour daily to shower, use the dayroom, or go to yard. When he
3 does go to dayroom, he is in the presence of a dozen or more detainees, none of
4 whom are required to wear masks. The detainees appear to have arrived at the unit
5 from a variety of places and are mixed together. The conditions in the unit and in
6 his cell are unsanitary. He said he “begged for three days” when he returned from
7 the hospital, attempting to get materials with which to clean his cell, noting “I tried
8 to clean [it] using my own shirt since I had nothing else.” According to Mr. Soto,
9 the medical monitoring consists of nothing more than morning cell-front visit from
10 a nurse who takes the detainees’ temperatures but does not ask them about other
11 symptoms. It does not appear he had any checks by mental health staff. Monitoring
12 by security staff is superficial and pro forma: “The have a little electronic tube that
13 they hit on the door but I have observed that they do not look inside the cell to
14 make sure we are okay. I am very worried that I am going to have more heart
15 issues and will die without them noticing.” Mr. Soto has never had a COVID-19
16 test, including when he returned from the hospital, and reported that he has not
17 seen anyone else in his unit receive one either.

18 21. The three declarations from Alex Hernandez provide another harrowing
19 example of ICE’s lockdown strategy during the Pandemic. Mr. Hernandez is 49
20 years old. He is currently detained in ICE custody at the Etowah County Detention
21 Center in Gadsden, Alabama and has been there since October 2016. He has
22 hypertension, Barrett’s esophagus (puts him at higher risk of cancer), is in recovery
23 from shoulder surgery in November 2019, and has not had an endoscopy or biopsy
24 since being in ICE custody. He has not received physical therapy or a specialist
25 evaluation since COVID-19 began. On March 20, 2020 when detainees in Mr.
26 Hernandez’s cell tied nooses around their necks and threatened suicide to stop staff
27 from bringing in transfers to their cell (sick transfers especially), Mr. Hernandez’s
28 housing unit was put in lockdown. His unit was not allowed to participate in

1 programs and was only allowed two half-hour increments daily to shower and
2 make phone calls. No one from medical evaluated their unit, not even to take body
3 temperatures.

4 22. Mr. Hernandez shared his cell with another individual until the end of May,
5 and they were locked in the cell together for 21 hours a day, 7 days a week for over
6 a month. He states it was extremely stressful being isolated with another person in
7 such confined quarters. They only had old National Geographic magazines and the
8 Bible to read. Now, Mr. Hernandez is in a cell by himself for approximately 19.5
9 hours a day. All he can do is read magazines, listen to the radio, and sleep. His
10 dorm is let out of lockdown 4.5 hours a day (40 people at a time – 2 floors, 40
11 people each floor). He has ten minutes to eat each meal (30 minutes total a day),
12 and then four 1-hour periods spread through the day (morning, afternoon, evening)
13 to shower, visit the law library, watch tv, use the phone, and go to recreation. He is
14 stressed, anxious, and worried every day. He has never received a COVID-19 test
15 and has never had his temperature taken by a nurse.

16 23. I reviewed a letter from the Southern Poverty Law Center on behalf of a
17 client detained at Pine Prairie who was placed in the disciplinary solitary
18 confinement area of Pine Prairie upon return from the hospital. This appears to be
19 Pine Prairie's attempt to medically isolate this client after possible COVID-19
20 exposure in the hospital, although it is in reality punitive segregation under harsh
21 conditions. The client has reported to SPLC that he is feeling heightened stress,
22 medical complications, and higher levels of suicidality.

23 24. I also reviewed a declaration from class member Oscar Perez Aguirre, who
24 tested positive for COVID-19 while in ICE custody at the Aurora Detention
25 Center. Mr. Perez Aguirre describes stark conditions both in the medical isolation
26 unit he initially was housed in for quarantine upon intake and in the unit normally
27 used for disciplinary segregation where he was placed upon return from the
28

1 hospital, while he was still symptomatic. He had nothing to do in either cell and no
2 support from mental health staff, and reported increasing psychiatric distress
3 during his stay.

4 25. According to news reports I reviewed, a detained person at Mesa Verde with
5 a history of mental illness and suicide attempts died by suicide after being placed
6 in medical isolation upon returning from the hospital.

7 Contravention of the CDC Guidelines
8

9 26. The anecdotes above indicate that ICE's lockdown practices are inconsistent
10 with the CDC Guidelines issued March 23, 2020, referenced above.

11 27. First and most fundamentally, the CDC at no point indicates that people
12 should be placed in the extreme isolation and stark conditions described by Mr.
13 Mencias Soto and Mr. Perez Aguirre. While the CDC does make the
14 recommendation that every person in quarantine should be in a single cell, it does
15 not recommend that they be in 23-hour lockdown, as Mr. Mencias Soto was. Nor
16 do they recommend that every person in quarantine should be placed in
17 disciplinary segregation cells, or deprived of reading materials, television, or cards,
18 without mental health support—all conditions to which both Mr. Mencias Soto and
19 Mr. Perez Aguirre were subjected to.

20 28. Second, Mr. Mencias Soto appears to have been placed in disciplinary
21 segregation in order to quarantine following his possible COVID-19 exposure in
22 the hospital. He reports that other people in the unit were new arrivals at the
23 facility, and others were moved in from other parts of the facility. This is
24 inconsistent with the CDC recommendation not to mix people quarantined for
25 different reasons. Further, the constant flow of detainees in and out of the
26 disciplinary unit that Mr. Mencias Soto described is inconsistent with the CDC
27 recommendation not to introduce new people into an existing quarantine.
28

1 29. Third, the double-celled dormitory extended lockdown that Mr. Hernandez
2 describes is completely at odds with CDC guidelines on infection control, which
3 frankly do not contemplate anything so psychologically stressful and potentially
4 counter-productive. Moreover, Mr. Hernandez gives no indication that any steps
5 were taken within this practice to reduce the exposure to high risk individuals like
6 himself, which the CDC recommends.

7 Further Opinion on Risk of Harm from ICE's Lockdown Practices in the Pandemic
8

9 30. Of course, in units like the one in which Mr. Mencias Soto is living as well
10 as other ICE detention facilities, there are only very limited ways of protecting
11 detainees from contact with staff who regularly enter the facility after having been
12 in the outside world. Staff members are at risk of having contracted COVID-19
13 and then transmitting it to all those inside the institutions, including to detainees
14 and other staff members.

15 31. These procedures are inappropriate, ill-conceived, and counter-productive
16 for several reasons. In fact, they could very likely exacerbate rather than limit or
17 alleviate the spread of COVID-19.¹⁰ For one, as Mr. Hernandez's declarations
18 described above attest to, general population housing units essentially have been
19 turned into onerous lockdown units, which greatly increase the psychological stress
20 under which detainees live, potentially leading to increased mental and physical

21 ¹⁰ It is important to note that "shelter in place" or "stay at home" orders are not
22 remotely the same thing as "lockdown" or "solitary confinement" as the latter are
23 practiced in ICE detention facilities. Detainees are locked in cells the size of a very
24 small bathroom or a parking space, where they are confined essentially around-the-
25 clock, without access to cell phones or other electronic devices (that persons
26 sheltering in place are using to remain social connected and engaged), even more
27 limited access to cleaning and disinfectant materials, reduced medical and
28 psychological services on which they are completely dependent, and drastic
reductions in personal property. Few if any persons in free society are subjected to
restrictions remotely this onerous.

1 deterioration, interpersonal conflicts, and self-harm and suicidality. The fact that
2 detainees may be double-celled during these lockdowns, as Mr. Hernandez was for
3 months, does not mitigate the negative effects of their essentially around-the-clock
4 in-cell confinement. In fact, double-celling may exacerbate these effects because of
5 the interpersonal tensions and stressors that such unavoidably close around-the-
6 clock contact generates.

7 32. ICE quarantines and medical isolation are now being operationalized in
8 ways that are essentially identical to the solitary confinement-type housing that has
9 been shown to place detained persons at significant risk of grave harm (including
10 harm that may be permanent, even fatal). Thus, there is a large literature on the
11 adverse psychological and physical effects of the kind of isolation to which ICE
12 detainees are now being subjected. This literature establishes a range of damaging
13 consequences that come about when persons are subjected to the kinds of
14 conditions that now prevail inside many ICE facilities.

15 33. Specifically, lockdowns and solitary confinement subject persons to a
16 separate set of very serious harmful effects, ones that significantly undermine their
17 mental and physical well-being and risk doing far more harm than good. The
18 scientific literature on the harmfulness of solitary confinement is now widely
19 accepted and the research findings are consistent and alarming.¹¹ This research has
20

21 ¹¹ These many studies have been carefully reviewed in a number of publications.
22 For example, see: K. Cloyes, D. Lovell, D. Allen & L. Rhodes, Assessment of
23 psychosocial impairment in a super-maximum security unit sample, *Criminal*
24 *Justice and Behavior*, 33, 760-781 (2006); S. Grassian, Psychiatric effects of
25 solitary confinement. *Washington University Journal of Law & Policy*, 22, 325-
26 383 (2006); C. Haney, Restricting the use of solitary confinement. *Annual Review*
27 *of Criminology*, 1, 285-310 (2018); C. Haney & M. Lynch, Regulating prisons of
28 the future: The psychological consequences of solitary and supermax confinement.
New York Review of Law & Social Change, 23, 477-570 (1997); and P. Smith, The
effects of solitary confinement on prison inmates: A brief history and review of the

1 led a number of professional mental and physical health-related, legal, human
2 rights, and even correctional organizations to call for severe limitations on the
3 degree to which solitary confinement is employed—specifically limiting when, for
4 how long, and on whom it can be imposed.¹²

5 34. Although the adverse effects of isolated confinement are prevalent among
6 populations of persons subjected to them, and serious enough to jeopardize the
7 physical and psychological well-being of everyone exposed to them, the risk of
8 harm is especially great for persons with pre-existing mental health conditions,
9 including persons with diagnosed psychiatric disorders and others with
10 psychological vulnerabilities that may worsen during confinement. This group of
11 people are particularly likely to decompensate, suffer worsening depression, and
12 much more frequently engage in self-harming and suicidal behavior in response to
13 social isolation. There are several reasons for this, including the fact that solitary
14 confinement is an especially psychologically stressful experience (one that even
15 mentally stable persons struggle to tolerate), and mentally ill and psychiatrically
16 vulnerable persons react especially adversely to increased stress. In addition, many
17 of the specific psychological reactions that are produced by solitary confinement—
18 depression, anxiety, and cognitive disturbances—parallel the symptoms of the very
19 conditions from which many psychiatrically vulnerable detainees suffer, adding to
20 the level or degree of their psychological disability.

21 35. For these reasons, psychologically vulnerable detainees should be excluded
22 from all forms of severe social isolation (i.e., lockdowns and solitary confinement).

23 literature, in Michael Tonry (Ed.), *Crime and Justice* (pp. 441-528). Volume 34.
24 Chicago: University of Chicago Press (2006).

25 ¹² For a list of these organizations and their specific recommendations, see: Haney,
26 C. (2018) Restricting the use of solitary confinement. *Annual Review of*
27 *Criminology*, 1, 285-310; Haney, C., Ahalt, C., & Williams, B., et al. (2020).
28 Consensus statement of the Santa Cruz summit on solitary confinement.
Northwestern Law Review, in press.

1 If they cannot be, then at the very minimum, they must be given access to
2 enhanced psychological services as well as enhanced screening for potentially
3 emerging mental health diagnoses and disabilities. As I noted earlier, clinical and
4 subclinical mental health disabilities are subject to change. These conditions,
5 especially, are likely to be exacerbated by heightened levels of stress. The
6 determination of whether a particular mental health condition warrants special
7 disability-related protections cannot be made mechanically or merely by reference
8 to a list of potentially qualifying diagnoses, but rather should be subject to period
9 assessment. This means that detainees' mental health status must be periodically
10 reassessed and the need for disability-related accommodations determined on a
11 continuous basis.

12 36. Yet, based on my many years of studying correctional systems and practices
13 across the country, I know that increased periodic assessment and ameliorative
14 measures such as increased treatment and out of cell time will be among the first
15 things that are suspended as the system diverts staff to address emergencies (such
16 as the Pandemic). It is certainly the case that, based on the documents I reviewed,
17 mental health support for people currently experiencing solitary confinement or
18 lockdown is insufficient. This means that mentally ill detainees are at grave risk of
19 decompensation.

20 37. In addition, the kind of onerous lockdowns that many ICE facilities have
21 imposed may lead to the COVID-19 virus going undetected. Lockdowns decrease
22 the interactions that detainees have with facility staff, including healthcare
23 providers, compromising the latter's ability to identify symptoms. Moreover, the
24 even more onerous conditions that ICE imposes on detainees who are placed
25 medical isolation likely serve as a disincentive for them to report their own
26 symptoms. Detainees understandably do not want to be placed in insect-infested,
27
28

1 dirty solitary confinement-like cells where they will spend two weeks without
2 access to telephones or showers.

3 38. Finally, it is possible that the extraordinary added stress of social isolation
4 under these especially onerous conditions—in general population “lockdown,” in
5 medical isolation cells, and in quarantine—are so extreme that they will operate to
6 depress detainees’ immune systems and render them even more vulnerable to
7 COVID-19 virus, and less able to combat it if and when they contract it.¹³

8 39. In light of these facts and this panoply of very serious, well-established
9 risks, it is my professional opinion that ICE must urgently take steps to implement
10 existing CDC guidelines without resort to preemptive lockdown procedures or
11 imposing severe solitary-confinement conditions for purposes of medical isolation
12 of positive patients.

13 40. In addition, even if the CDC guidelines are implemented, ICE should take
14 all feasible steps to significantly reduce the population of detainees it confines.
15 Every detainee who can be safely released must be. ICE should also assess that
16 placement in the community can be reasonably accommodated for people with
17 mental health disabilities.

18
19
20
21 ¹³ Dhabhar, F. S. (2014). Effects of stress on immune function: The good, the bad,
22 and the beautiful. *Immunologic Research*, 58(2), 193–
23 210. <https://doi.org/10.1007/s12026-014-8517-0>. In addition, as Louise Hawkley
24 summarized, a “growing body of research suggests that people who are socially
25 isolated have increased rates of hypertension, chronic cardiovascular diseases such
26 as heart disease and stroke, and early mortality.” Hawkley, L. (2020). Social
27 isolation, loneliness, and health, in Jules Lobel & Peter Scharff Smith (eds.),
28 *Solitary confinement: Effects, practices, and pathways toward reform* (pp.185-198).
New York: Oxford University Press, p. 195. Thus, in addition to the effects of
stress, social isolation makes people less healthy in general, and likely more
susceptible to pathogens such as COVID-19.

1 41. It is also my opinion that, unless immediate measures are taken to implement
2 the CDC guidelines for responding to the COVID-19 Pandemic, and to
3 significantly reduce the population of persons housed in ICE detention facilities
4 needless suffering and loss of life are likely to occur.

5 42. With respect to lockdown procedures, I urgently recommend that ICE
6 facilities cease employing general, preemptive lockdowns, wherein detainees are
7 confined to their cells. Instead, ICE should institute such lockdowns only where
8 medically necessary to resolve discrete issues, such as sanitizing dorms or contact
9 tracing of an infected detainee. If and when ICE must resort to these lockdowns, it
10 should do so in a reasonably time-limited manner and communicate that time-limit
11 to the detainees who are affected. Moreover, if lockdowns are employed, ICE
12 should ensure detainees' access to resources to protect their mental health, such as
13 reading material and adequate access to phones, and trained ICE facility medical
14 and mental health staff should regularly communicate with and monitor the
15 physical and mental health of detainees who are on lockdown.

16 43. In addition, as I stated above, I believe that ICE must avoid the use of
17 lockdown procedures with detainees who suffer pre-existing mental health
18 conditions unless they are absolutely necessary. If psychologically vulnerable
19 detainees must go on lockdown, ICE facility personnel should ensure that the
20 lockdown is as brief as reasonably possible, and that these detainees are provided
21 with *enhanced* psychological services while they are on lockdown.

22 44. With respect to ICE's quarantine and medical isolation procedures, they
23 should be configured and operated in ways that mitigate the psychological stress of
24 isolation. This means that only those persons who have confirmed or suspected
25 cases of COVID-19 are placed in medical isolation (and released as soon as
26 medical evidence indicates they are no longer contagious). The units themselves
27 should be overseen by medical (not security) personnel and maintain heightened
28

1 sanitary and other environmentally appropriate and adequate conditions (proper
2 light, temperature, and ventilation). In addition, they should provide patients with
3 *enhanced* access to personal hygiene supplies, clean water, changes of clothes,
4 reading material, television, and methods of communicating with loved ones,
5 attorneys and advocates. (Of course, telephones should be disinfected.)

6 45. Detainees should remain in isolated for the shortest amount of time
7 reasonably possible to satisfy the CDC guidelines. Finally, medically isolated
8 detainees should be checked regularly by ICE facility medical staff and given
9 regular access to psychological services. These steps are critical for all detainees.
10 They are particularly critical for psychologically vulnerable detainees.

11 46. It is my opinion that, unless these steps are taken to end general, preemptive
12 lockdowns and solitary confinement-like isolation and to mitigate the
13 psychological stress of temporary lockdowns and medical isolation procedures, for
14 all detainees but especially for those with pre-existing mental illness and
15 psychiatric vulnerability, ICE detainees will face grave dangers to their mental and
16 physical health.

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

18 Executed on June 24, 2020 at Santa Cruz, California.
19
20

21 **Craig W. Haney, Ph.D.** [signed electronically]
22

23 _____
24 DR. CRAIG W. HANEY, PH.D.
25
26
27
28

EXHIBIT A

Exhibit A

CURRICULUM VITAE

Craig William Haney
Distinguished Professor of Psychology
UC Presidential Chair, 2015-2018
University of California, Santa Cruz 95064

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PREVIOUS EMPLOYMENT

2015-2018	University of California Presidential Chair
2014-present	Distinguished Professor of Psychology, University of California, Santa Cruz
1985-2014	University of California, Santa Cruz, Professor of Psychology
1981-85	University of California, Santa Cruz, Associate Professor of Psychology
1978-81	University of California, Santa Cruz, Assistant Professor of Psychology
1977-78	University of California, Santa Cruz, Lecturer in Psychology
1976-77	Stanford University, Acting Assistant Professor of Psychology

EDUCATION

1978	Stanford Law School, J.D.
1978	Stanford University, Ph.D. (Psychology)

Exhibit A

1972	Stanford University, M.A. (Psychology)
1970	University of Pennsylvania, B.A.

HONORS AWARDS GRANTS

2020	Finalist, Stockholm Prize in Criminology (for “outstanding achievements in criminological research or for the application of research results by practitioners for the reduction of crime and the advancement of human rights”).
2018	Emerald Literati Award for “Outstanding Paper” (for “Reducing the Use and Impact of Solitary Confinement in Corrections”).
2016	Vera Institute of Justice “Reimagining Prisons” Initiative Advisory Council. Psychology Department “Most Inspiring Lecturer”
2015	University of California Presidential Chair (2015-2018 Term) Martin F. Chemers Award for Outstanding Research in Social Science Excellence in Teaching Award (Academic Senate Committee on Teaching). President’s Research Catalyst Award for “UC Consortium on Criminal Justice Healthcare” (with Brie Williams and Scott Allen). Vera Institute of Justice “Safe Alternatives to Segregation” (SAS) Initiative Advisory Council. Who’s Who in Psychology (Top 20 Psychology Professors in California) [http://careersinpsychology.org/psychology-degrees-schools-employment-ca/#ca-psych-prof]
2014	Distinguished Faculty Research Lecturer, University of California, Santa Cruz.
2013	Distinguished Plenary Speaker, American Psychological Association Annual Convention.

Exhibit A

- 2012 Appointed to National Academy of Sciences Committee to Study the Causes and Consequences of High Rates of Incarceration in the United States.
- Invited Expert Witness, United States Senate, Judiciary Committee.
- 2011 Edward G. Donnelly Memorial Speaker, University of West Virginia Law School.
- 2009 Nominated as American Psychological Foundation William Bevan Distinguished Lecturer.
- Psi Chi “Best Lecturer” Award (by vote of UCSC undergraduate psychology majors).
- 2006 Herbert Jacobs Prize for Most Outstanding Book published on law and society in 2005 (from the Law & Society Association, for Death by Design).
- Nominated for National Book Award (by American Psychological Association Books, for Reforming Punishment: Psychological Limits to the Pains of Imprisonment).
- “Dream course” instructor in psychology and law, University of Oklahoma.
- 2005 Annual Distinguished Faculty Alumni Lecturer, University of California, Santa Cruz.
- Arthur C. Helton Human Rights Award from the American Immigration Lawyers Association (co-recipient).
- Scholar-in-Residence, Center for Social Justice, Boalt Hall School of Law (University of California, Berkeley).
- 2004 “Golden Apple Award” for Distinguished Teaching, awarded by the Social Sciences Division, University of California, Santa Cruz.
- National Science Foundation Grant to Study Capital Jury Decision-making
- 2002 Santa Cruz Alumni Association Distinguished Teaching Award, University of California, Santa Cruz.

Exhibit A

United States Department of Health & Human Services/Urban Institute, "Effects of Incarceration on Children, Families, and Low-Income Communities" Project.

American Association for the Advancement of Science/American Academy of Forensic Science Project: "Scientific Evidence Summit" Planning Committee.

Teacher of the Year (UC Santa Cruz Re-Entry Students' Award).

2000 Invited Participant White House Forum on the Uses of Science and Technology to Improve National Crime and Prison Policy.

Excellence in Teaching Award (Academic Senate Committee on Teaching).

Joint American Association for the Advancement of Science-American Bar Association Science and Technology Section National Conference of Lawyers and Scientists.

1999 American Psychology-Law Society Presidential Initiative Invitee ("Reviewing the Discipline: A Bridge to the Future")

National Science Foundation Grant to Study Capital Jury Decision-making (renewal and extension).

1997 National Science Foundation Grant to Study Capital Jury Decision-making.

1996 Teacher of the Year (UC Santa Cruz Re-Entry Students' Award).

1995 Gordon Allport Intergroup Relations Prize (Honorable Mention)

Excellence in Teaching Convocation, Social Sciences Division

1994 Outstanding Contributions to Preservation of Constitutional Rights, California Attorneys for Criminal Justice.

1992 Psychology Undergraduate Student Association Teaching Award

SR 43 Grant for Policy-Oriented Research With Linguistically Diverse Minorities

1991 Alumni Association Teaching Award ("Favorite Professor")

1990 Prison Law Office Award for Contributions to Prison Litigation

Exhibit A

1989	UC Mexus Award for Comparative Research on Mexican Prisons
1976	Hilmer Oehlmann Jr. Award for Excellence in Legal Writing at Stanford Law School
1975-76	Law and Psychology Fellow, Stanford Law School
1974-76	Russell Sage Foundation Residency in Law and Social Science
1974	Gordon Allport Intergroup Relations Prize, Honorable Mention
1969-71	University Fellow, Stanford University
1969-74	Society of Sigma Xi
1969	B.A. Degree <u>Magna cum laude</u> with Honors in Psychology Phi Beta Kappa
1967-1969	University Scholar, University of Pennsylvania

UNIVERSITY SERVICE AND ADMINISTRATION

2010-2016	Director, Legal Studies Program
2010-2014	Director, Graduate Program in Social Psychology
2009	Chair, Legal Studies Review Committee
2004-2006	Chair, Committee on Academic Personnel
1998-2002	Chair, Department of Psychology
1994-1998	Chair, Department of Sociology
1992-1995	Chair, Legal Studies Program
1995 (Fall)	Committee on Academic Personnel
1995-1996	University Committee on Academic Personnel (UCAP)
1990-1992	Committee on Academic Personnel

Exhibit A

1991-1992	Chair, Social Science Division Academic Personnel Committee
1984-1986	Chair, Committee on Privilege and Tenure

WRITINGS AND OTHER CREATIVE ACTIVITIES IN PROGRESS

Books:

Counting Casualties in the War on Prisoners: Toward a Just and Lasting Peace (working title, in preparation).

Articles:

“The Psychological Foundations of Capital Mitigation: Why Social Historical Factors Are Central to Assessing Culpability,” in preparation.

PUBLISHED WRITINGS AND CREATIVE ACTIVITIES

Books

2020	<u>Criminality in Context: The Psychological Foundations of Criminal Justice Reform</u> . Washington, DC: American Psychological Association Books.
2014	<u>The Growth of Incarceration in the United States: Exploring the Causes and Consequences</u> (with Jeremy Travis, Bruce Western, et al.). [Report of the National Academy of Sciences Committee on the Causes and Consequences of High Rates of Incarceration in the United States.] Washington, DC: National Academy Press.
2006	<u>Reforming Punishment: Psychological Limits to the Pains of Imprisonment</u> , Washington, DC: American Psychological Association Books.
2005	<u>Death by Design: Capital Punishment as a Social Psychological System</u> . New York: Oxford University Press.

Monographs and Technical Reports

Exhibit A

- 1989 Employment Testing and Employment Discrimination (with A. Hurtado). Technical Report for the National Commission on Testing and Public Policy. New York: Ford Foundation.

Articles in Professional Journals and Book Chapters

- 2020 “Solitary Confinement, Loneliness, and Psychological Harm,” in Jules Lobel and Peter Scharff Smith (Eds.), Solitary Confinement: Effects, Practices, and Pathways to Reform (129-152). New York: Oxford University Press.
- “Continuing to Acknowledge the Power of Dehumanizing Environments: Responding to Haslam, et al. (2019) and Le Texier (2019)” (with Philip Zimbardo), American Psychologist, 75(3), 400-402.
- “Solitary Confinement is Not Solitude: The Worst Case Scenario of Being ‘Along’ in Prison,” in Robert Coplan, Julie Bowker, & Larry Nelson (Eds.), Handbook of Solitude: Psychological Perspectives on Isolation, Social Withdrawal, and Being Alone. Second Edition. New York: Wiley-Blackwell, in press.
- “Sykes’s prison in context: and solitary: Change and continuity in the life span of a penitentiary,” in B. Crewe, A. Goldsmith, & M. Halsey (Eds.), Power and authority in the modern prison: Revisiting the Society of Captives. New York: Oxford University Press, in press.
- 2019 “Afterword,” in Robert Johnson, Condemned to Die: Life Under Sentence of Death (pp. 136-141). Second Edition. New York: Routledge.
- “Changing correctional culture: Exploring the role of U.S.-Norway exchange in placing health and well-being at the center of U.S. prison reform” (with Cyrus Ahalt, Brie Williams, and Kim Ekhaugen), American Journal of Public Health, in press.
- 2018 “Restricting the Use of Solitary Confinement,” Annual Review of Criminology, 1, 285-310.

Exhibit A

“Death Qualification in Black and White: Racialized Decision-Making and Death-Qualified Juries” (with Mona Lynch), Law & Policy, 40(2), 148-171.

“Balancing the Rights to Protection and Participation: A Call for Expanded Access to Ethically Conducted Correctional Research. Journal of General Internal Medicine, 33(22). DOI: 10.1007/s11606-018-4318-9.

“The Plight of Long-Term Mentally-Ill Prisoners” (with Camille Conrey and Roxy Davis), in Kelly Frailing and Risdon Slate (Eds.), The Criminalization of Mental Illness (pp. 163-180). Durham, NC: Carolina Academic Press.

“The Psychological Effects of Solitary Confinement: A Systematic Critique,” Crime and Justice, 47, 365-416.

“The Media’s Impact on the Right to a Fair Trial: A Content Analysis of Pretrial Publicity in Capital Cases (with Shirin Bakhshay), Psychology, Public Policy, and Law, 24, 326-346.

2017 “Mechanisms of Moral Disengagement and Prisoner Abuse” (with Joanna Weill). Analyses of Social Issues and Public Policy, 17, 286-318.

“‘Madness’ and Penal Confinement: Observations on Mental Illness and Prison Pain,” Punishment and Society, 19, 310-326.

“Contexts of Ill-Treatment: The Relationship of Captivity and Prison Confinement to Cruel, Inhuman, or Degrading Treatment and Torture” (with Shirin Bakhshay), in Metin Başoğlu (Ed.), Torture and Its Definition in International Law: An Interdisciplinary Approach (pp.139-178). New York: Oxford.

Special Issue: “Translating Research into Policy to Advance Correctional Health” (guest editor with B. Williams, C. Ahalt, S. Allen, & J. Rich), Part II, International Journal of Prisoner Health, 13, 137-227.

“Reducing the Use and Impact of Solitary Confinement in Corrections” (with Cyrus Ahalt, Sarah Rios, Matthew Fox, David Farabee, and Brie Williams), International Journal of Prisoner Health, 13, 41-48.

Exhibit A

- 2016 “Examining Jail Isolation: What We Don’t Know Can Be Profoundly Harmful” (with Joanna Weill, Shirin Bakhshay, and Tiffany Winslow), The Prison Journal, 96, 126-152.
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MEMBERSHIP/ACTIVITIES IN PROFESSIONAL ASSOCIATIONS

American Psychological Association
American Psychology and Law Society
Law and Society Association
National Council on Crime and Delinquency

INVITED ADDRESSES AND PAPERS PRESENTED AT PROFESSIONAL ACADEMIC MEETINGS AND RELATED SETTINGS (SELECTED)

Exhibit A

- 2019 “The Recent History of Corrections in Norway and the United States,” Plenary Address, Justice Reinvestment Summit, Salem, OR, February.
- “The Dimensions of Suffering in Solitary Confinement,” Plenary Address, Washington College of Law at American University, Washington, DC, March.
- “Implementing Norwegian Correctional Principles to Change Prison Culture in Oregon Prisons,” Invited Address, Oregon Department of Corrections Leadership Team, Salem, OR, June.
- “Humanizing American Jails and Prisons,” Center for Court Innovation, International Summit, New York, NY, June.
- “From the Stanford Prison Experiment to Supermax Prisons and Back Again: Changing the Narrative in Criminal Justice Reform,” Invited Address, Norwegian Correctional Academy, Oslo, Norway, September.
- Plenary Address, “Perspectives on Solitary Confinement,” Northwestern University Law Review Symposium, Chicago, IL, November.
- 2018 “The Art and Science of Capital Mitigation,” Federal Death Penalty Training Conference, Atlanta, Georgia, June.
- “From Eastern State Penitentiary to Supermax Prisons,” Safe Alternatives to Segregation Conference, Vera Institute of Justice, Philadelphia, PA, June.
- Plenary Address, “Advancing Prisoners’ Rights Through Law and Psychology,” Denver Law Prisoners’ Advocates Conference, University of Denver Sturm College of Law, Denver, CO, October.
- “In Praise of Positivism in the Age of ‘Fake News’ and ‘Alternative Facts,’” Research Frontiers Conference, Santa Cruz, CA, October.
- 2017 “Neuroscience in Policy: Solitary Confinement in California,” Law & Neuroscience Conference, San Francisco, CA, February.

Exhibit A

“In My Solitude: The Detrimental Effects of Solitary Confinement on the Brain,” Exploratorium-Fisher Bay Observation Gallery, San Francisco, CA, February.

“Brief History of Correctional Reform in the United States,” Community Corrections Partnership/Smart on Crime Community Forum, Santa Cruz Civic Auditorium, May.

“Reducing and Eliminating the Use of Solitary Confinement in Irish Prisons,” Joint Conference with the Irish Prison Service, Department of Justice, and Irish Penal Reform Trust, Dublin, Ireland, June.

“The Emerging Consensus on When, for How Long, and On Whom Solitary Confinement Should Ever Be Imposed,” Leadership, Culture and Managing Prisons: Knowledge Exchange between the USA and Europe (LEADERS), Trinity College, Dublin, Ireland, June.

“Sykes and Solitary: The Transformation of the Penal Subject in the Devolution from a ‘Society of Captives’ to Supermax Prisons,” Power and Authority in Modern Prisons: Essays in Memory of Gresham Sykes Workshop, Centre for Prison Research, Cambridge University, Cambridge, England, September.

“Context Is Everything: The Social Psychology of Imprisonment,” Joint USA/Scandinavian Correctional Exchange Program, Oslo, Norway, September.

2016 “The Culture of Punishment,” American Justice Summit, New York, January.

“Mental Illness and Prison Confinement,” Conference on Race, Class, Gender and Ethnicity (CRCGE), University of North Carolina Law School, Chapel Hill, NC, February.

“Reforming the Treatment of California’s Mentally Ill Prisoners: Coleman and Beyond,” Meeting of the UC Consortium on Criminal Justice & Health, San Francisco, April.

“Bending Toward Justice? The Urgency (and Possibility) of Criminal Justice Reform,” UC Santa Cruz Alumni Association “Original Thinkers” Series, San Jose, CA (March), and Museum of Tolerance, Los Angeles (April).

Exhibit A

“Isolation and Mental Health,” International and Inter-Disciplinary Perspectives on Prolonged Solitary Confinement, University of Pittsburgh Law School, Pittsburgh, PA, April.

“Mechanisms of Moral Disengagement in the Treatment of Prisoners” (with Joanna Weill), Conference of the Society for the Study of Social Issues, Minneapolis, June.

- 2015 “Reforming the Criminal Justice System,” Bipartisan Summit on Criminal Justice Reform, American Civil Liberties Union/Koch Industries co-sponsored, Washington, DC, March.
- “PrisonWorld: How Mass Incarceration Transformed U.S. Prisons, Impacted Prisoners, and Changed American Society,” Distinguished Faculty Research Lecture, UC Santa Cruz, March.
- “Think Different, About Crime and Punishment,” Invited Lecture, UC Santa Cruz 50th Anniversary Alumni Reunion, April.
- “The Intellectual Legacy of the Civil Rights Movement: Two Fifty-Year Anniversaries,” College 10 Commencement Address, June.
- “Race and Capital Mitigation,” Perspectives on Racial and Ethnic Bias for Capital and Non-Capital Lawyers, New York, September.
- “The Dimensions of Suffering in Solitary Confinement,” Vera Institute of Justice, “Safe Alternatives to Solitary Confinement-A Human Dignity Approach” Conference, Washington, DC, September.
- “Mental Health and Administrative Segregation,” Topical Working Group on the Use of Administrative Segregation in the U.S., National Institute of Justice/Department of Justice, Washington, DC, October.
- “The Psychological Effects of Segregated Confinement,” Ninth Circuit Court of Appeals “Corrections Summit,” Sacramento, CA, November.
- “How Can the University of California Address Mass Incarceration in California and Beyond?,” Keynote Address, Inaugural Meeting of the UC Consortium on Criminal Justice & Health, San Francisco, November.

Exhibit A

- 2014 “Solitary Confinement: Legal, Clinical, and Neurobiological Perspectives,” American Association for the Advancement of Science (AAAS), Chicago, IL February.
- “Overcrowding, Isolation, and Mental Health Care, Prisoners’ Access to Justice: Exploring Legal, Medical, and Educational Rights,” University of California, School of Law, Irvine, CA, February.
- “The Continuing Significance of Death Qualification” (with Joanna Weill), Annual Conference of the American Psychology-Law Society, New Orleans, March.
- “Using Psychology at Multiple Levels to Transform Adverse Conditions of Confinement,” Society for the Study of Social Issues Conference, Portland, OR, June.
- “Humane and Effective Alternatives to Isolated Confinement,” American Civil Liberties Union National Prison Project Convening on Solitary Confinement, Washington, DC, September.
- “Community of Assessment of Public Safety,” Community Assessment Project of Santa Cruz County, Year 20, Cabrillo College, November.
- “Overview of National Academy of Sciences Report on Causes and Consequences of High Rates of Incarceration,” Chief Justice Earl Warren Institute on Law & Social Policy, Boalt Hall Law School, Berkeley, CA, November.
- “Presidential Panel, Overview of National Academy of Sciences Report on Causes and Consequences of High Rates of Incarceration,” American Society for Criminology, San Francisco, November.
- “Presidential Panel, National Academy of Sciences Report on Consequences of High Rates of Incarceration on Individuals,” American Society for Criminology, San Francisco, November.
- “Findings of National Academy of Sciences Committee on the Causes and Consequences of High Rates of Incarceration,” Association of Public Policy Analysis and Management Convention (APPAM), Albuquerque, NM, November.

Exhibit A

“Politics and the Penal State: Mass Incarceration and American Society,” New York University Abu Dhabi International Scholars Program, Abu Dhabi, United Arab Emirates, December.

2013 “Isolation and Mental Health,” Michigan Journal of Race and Law Symposium, University of Michigan School of Law, Ann Arbor, MI, February.

“Social Histories of Capital Defendants” (with Joanna Weill), Annual Conference of Psychology-Law Society, Portland, OR, March.

“Risk Factors and Trauma in the Lives of Capital Defendants” (with Joanna Weill), American Psychological Association Annual Convention, Honolulu, HI, August.

“Bending Toward Justice: Psychological Science and Criminal Justice Reform,” Invited Plenary Address, American Psychological Association Annual Convention, Honolulu, HI, August.

“Severe Conditions of Confinement and International Torture Standards,” Istanbul Center for Behavior Research and Therapy, Istanbul, Turkey, December.

2012 “The Psychological Consequences of Long-term Solitary Confinement,” Joint Yale/Columbia Law School Conference on Incarceration and Isolation, New York, April.

“The Creation of the Penal State in America,” Managing Social Vulnerability: The Welfare and Penal System in Comparative Perspective, Central European University, Budapest, Hungary, July.

2011 “Tensions Between Psychology and the Criminal Justice System: On the Persistence of Injustice,” opening presentation, “A Critical Eye on Criminal Justice” lecture series, Golden Gate University Law School, San Francisco, CA, January.

“The Decline in Death Penalty Verdicts and Executions: The Death of Capital Punishment?” Presentation at “A Legacy of Justice” week, at the University of California, Davis King Hall Law School, Davis, CA, January.

Exhibit A

“Invited Keynote Address: The Nature and Consequences of Prison Overcrowding—Urgency and Implications,” West Virginia School of Law, Morgantown, West Virginia, March.

“Symposium: The Stanford Prison Experiment—Enduring Lessons 40 Years Later,” American Psychological Association Annual Convention, Washington, DC, August.

“The Dangerous Overuse of Solitary Confinement: Pervasive Human Rights Violations in Prisons, Jails, and Other Places of Detention” Panel, United Nations, New York, New York, October.

“Criminal Justice Reform: Issues and Recommendation,” United States Congress, Washington, DC, November.

2010 “The Hardening of Prison Conditions,” Opening Address, “The Imprisoned” Arthur Liman Colloquium Public Interest Series, Yale Law School, New Haven, CN, March.

“Desensitization to Inhumane Treatment: The Pitfalls of Prison Work,” panel presentation at “The Imprisoned” Arthur Liman Colloquium Public Interest Series, Yale Law School, New Haven, CN, March.

“Mental Ill Health in Immigration Detention,” Department of Homeland Security/DOJ Office for Civil Rights and Civil Liberties, Washington, DC, September.

2009 “Counting Casualties in the War on Prisoners,” Keynote Address, at “The Road to Prison Reform: Treating the Causes and Conditions of Our Overburdened System,” University of Connecticut Law School, Hartford, CN, February.

“Defining the Problem in California’s Prison Crisis: Overcrowding and Its Consequences,” California Correctional Crisis Conference,” Hastings Law School, San Francisco, CA, March.

2008 “Prisonization and Contemporary Conditions of Confinement,” Keynote Address, Women Defenders Association, Boalt Law School, University of California, November.

“Media Criminology and the Empathic Divide: The Continuing

Exhibit A

Significance of Race in Capital Trials,” Invited Address, Media, Race, and the Death Penalty Conference, DePaul University School of Law, Chicago, IL, March.

“The State of the Prisons in California,” Invited Opening Address, Confronting the Crisis: Current State Initiatives and Lasting Solutions for California’s Prison Conditions Conference, University of San Francisco School of Law, San Francisco, CA, March.

“Mass Incarceration and Its Effects on American Society,” Invited Opening Address, Behind the Walls Prison Law Symposium, University of California Davis School of Law, Davis, CA, March.

2007 “The Psychology of Imprisonment: How Prison Conditions Affect Prisoners and Correctional Officers,” United States Department of Justice, National Institute of Corrections Management Training for “Correctional Excellence” Course, Denver, CO, May.

“Statement on Psychologists, Detention, and Torture,” Invited Address, American Psychological Association Annual Convention, San Francisco, CA, August.

“Prisoners of Isolation,” Invited Address, University of Indiana Law School, Indianapolis, IN, October.

“Mitigation in Three Strikes Cases,” Stanford Law School, Palo Alto, CA, September.

“The Psychology of Imprisonment,” Occidental College, Los Angeles, CA, November.

2006 “Mitigation and Social Histories in Death Penalty Cases,” Ninth Circuit Federal Capital Case Committee, Seattle, WA, May.

“The Crisis in the Prisons: Using Psychology to Understand and Improve Prison Conditions,” Invited Keynote Address, Psi Chi (Undergraduate Psychology Honor Society) Research Conference, San Francisco, CA, May.

“Exoneration and ‘Wrongful Condemnation’: Why Juries Sentence to Death When Life is the Proper Verdict,” Faces of Innocence Conference, UCLA Law School, April.

Exhibit A

“The Continuing Effects of Imprisonment: Implications for Families and Communities,” Research and Practice Symposium on Incarceration and Marriage, United States Department of Health and Human Services, Washington, DC, April.

“Ordinary People, Extraordinary Acts,” National Guantanamo Teach In, Seton Hall School of Law, Newark, NJ, October.

“The Next Generation of Death Penalty Research,” Invited Address, State University of New York, School of Criminal Justice, Albany, NY, October.

2005 “The ‘Design’ of the System of Death Sentencing: Systemic Forms of ‘Moral Disengagement in the Administration of Capital Punishment, Scholar-in-Residence, invited address, Center for Social Justice, Boalt Hall School of Law (Berkeley), March.

“Humane Treatment for Asylum Seekers in U.S. Detention Centers,” United States House of Representatives, Washington, DC, March.

“Prisonworld: What Overincarceration Has Done to Prisoners and the Rest of Us,” Scholar-in-Residence, invited address, Center for Social Justice, Boalt Hall School of Law (Berkeley), March.

“Prison Conditions and Their Psychological Effects on Prisoners,” European Association for Psychology and Law, Vilnius, Lithuania, July.

2004 “Recognizing the Adverse Psychological Effects of Incarceration, With Special Attention to Solitary-Type Confinement and Other Forms of ‘Ill-Treatment’ in Detention,” International Committee of the Red Cross, Training Program for Detention Monitors, Geneva, Switzerland, November.

“Prison Conditions in Post-“War on Crime” Era: Coming to Terms with the Continuing Pains of Imprisonment,” Boalt Law School Conference, After the War on Crime: Race, Democracy, and a New Reconstruction, Berkeley, CA, October.

“Cruel and Unusual? The United States Prison System at the Start of the 21st Century,” Invited speaker, Siebel Scholars Convocation, University of Illinois, Urbana, IL, October.

Exhibit A

“The Social Historical Roots of Violence: Introducing Life Narratives into Capital Sentencing Procedures,” Invited Symposium, XXVIII International Congress of Psychology, Beijing, China, August.

“Death by Design: Capital Punishment as a Social Psychological System,” Division 41 (Psychology and Law) Invited Address, American Psychological Association Annual Convention, Honolulu, HI, July.

“The Psychology of Imprisonment and the Lessons of Abu Ghraib,” Commonwealth Club Public Interest Lecture Series, San Francisco, May.

“Restructuring Prisons and Restructuring Prison Reform,” Yale Law School Conference on the Current Status of Prison Litigation in the United States, New Haven, CN, May.

“The Effects of Prison Conditions on Prisoners and Guards: Using Psychological Theory and Data to Understand Prison Behavior,” United States Department of Justice, National Institute of Corrections Management Training Course, Denver, CO, May.

“The Contextual Revolution in Psychology and the Question of Prison Effects: What We Know about How Prison Affects Prisoners and Guards,” Cambridge University, Cambridge, England, April.

“Death Penalty Attitudes, Death Qualification, and Juror Instructional Comprehension,” American Psychology-Law Society, Annual Conference, Scottsdale, AZ, March.

2003

“Crossing the Empathic Divide: Race Factors in Death Penalty Decisionmaking,” DePaul Law School Symposium on Race and the Death Penalty in the United States, Chicago, October.

“Supermax Prisons and the Prison Reform Paradigm,” PACE Law School Conference on Prison Reform Revisited: The Unfinished Agenda, New York, October.

“Mental Health Issues in Supermax Confinement,” European Psychology and Law Conference, University of Edinburgh, Scotland, July.

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“Roundtable on Capital Punishment in the United States: The Key Psychological Issues,” European Psychology and Law Conference, University of Edinburgh, Scotland, July.

“Psychology and Legal Change: Taking Stock,” European Psychology and Law Conference, University of Edinburgh, Scotland, July.

“Economic Justice and Criminal Justice: Social Welfare and Social Control,” Society for the Study of Social Issues Conference, January.

“Race, Gender, and Class Issues in the Criminal Justice System,” Center for Justice, Tolerance & Community and Barrios Unidos Conference, March.

2002 “The Psychological Effects of Imprisonment: Prisonization and Beyond.” Joint Urban Institute and United States Department of Health and Human Services Conference on “From Prison to Home.” Washington, DC, January.

“On the Nature of Mitigation: Current Research on Capital Jury Decisionmaking.” American Psychology and Law Society, Mid-Winter Meetings, Austin, Texas, March.

“Prison Conditions and Death Row Confinement.” New York Bar Association, New York City, June.

2001 “Supermax and Solitary Confinement: The State of the Research and the State of the Prisons.” Best Practices and Human Rights in Supermax Prisons: A Dialogue. Conference sponsored by University of Washington and the Washington Department of Corrections, Seattle, September.

“Mental Health in Supermax: On Psychological Distress and Institutional Care.” Best Practices and Human Rights in Supermax Prisons: A Dialogue. Conference sponsored by University of Washington and the Washington Department of Corrections, Seattle, September.

“On the Nature of Mitigation: Research Results and Trial Process and Outcomes.” Boalt Hall School of Law, University of California, Berkeley, August.

Exhibit A

“Toward an Integrated Theory of Mitigation.” American Psychological Association Annual Convention, San Francisco, CA, August.

Discussant: “Constructing Class Identities—The Impact of Educational Experiences.” American Psychological Association Annual Convention, San Francisco, CA, August.

“The Rise of Carceral Consciousness.” American Psychological Association Annual Convention, San Francisco, CA, August.

- 2000 “On the Nature of Mitigation: Countering Generic Myths in Death Penalty Decisionmaking,” City University of New York Second International Advances in Qualitative Psychology Conference, March.
- “Why Has U.S. Prison Policy Gone From Bad to Worse? Insights From the Stanford Prison Study and Beyond,” Claremont Conference on Women, Prisons, and Criminal Injustice, March.
- “The Use of Social Histories in Capital Litigation,” Yale Law School, April.
- “Debunking Myths About Capital Violence,” Georgetown Law School, April.
- “Research on Capital Jury Decisionmaking: New Data on Juror Comprehension and the Nature of Mitigation,” Society for Study of Social Issues Convention, Minneapolis, June.
- “Crime and Punishment: Where Do We Go From Here?” Division 41 Invited Symposium, “Beyond the Boundaries: Where Should Psychology and Law Be Taking Us?” American Psychological Association Annual Convention, Washington, DC, August.
- 1999 “Psychology and the State of U.S. Prisons at the Millennium,” American Psychological Association Annual Convention, Boston, MA, August.
- “Spreading Prison Pain: On the Worldwide Movement Towards Incarcerative Social Control,” Joint American Psychology-Law Society/European Association of Psychology and Law Conference, Dublin, Ireland, July.

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- 1998 “Prison Conditions and Prisoner Mental Health,” Beyond the Prison Industrial Complex Conference, University of California, Berkeley, September.
- “The State of US Prisons: A Conversation,” International Congress of Applied Psychology, San Francisco, CA, August.
- “Deathwork: Capital Punishment as a Social Psychological System,” Invited SPPSI Address, American Psychological Association Annual Convention, San Francisco, CA, August.
- “The Use and Misuse of Psychology in Justice Studies: Psychology and Legal Change: What Happened to Justice?,” (panelist), American Psychological Association Annual Convention, San Francisco, CA, August.
- “Twenty Five Years of American Corrections: Past and Future,” American Psychology and Law Society, Redondo Beach, CA, March.
- 1997 “Deconstructing the Death Penalty,” School of Justice Studies, Arizona State University, Tempe, AZ, October.
- “Mitigation and the Study of Lives,” Invited Address to Division 41 (Psychology and Law), American Psychological Association Annual Convention, Chicago, August.
- 1996 “The Stanford Prison Experiment and 25 Years of American Prison Policy,” American Psychological Association Annual Convention, Toronto, August.
- 1995 “Looking Closely at the Death Penalty: Public Stereotypes and Capital Punishment,” Invited Address, Arizona State University College of Public Programs series on Free Speech, Affirmative Action and Multiculturalism, Tempe, AZ, April.
- “Race and the Flaws of the Meritocratic Vision,” Invited Address, Arizona State University College of Public Programs series on Free Speech, Affirmative Action and Multiculturalism, Tempe, AZ, April.
- “Taking Capital Jurors Seriously,” Invited Address, National Conference on Juries and the Death Penalty, Indiana Law School, Bloomington, February.

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- 1994 “Mitigation and the Social Genetics of Violence: Childhood Treatment and Adult Criminality,” Invited Address, Conference on the Capital Punishment, Santa Clara Law School, October, Santa Clara.
- 1992 “Social Science and the Death Penalty,” Chair and Discussant, American Psychological Association Annual Convention, San Francisco, CA, August.
- 1991 “Capital Jury Decisionmaking,” Invited panelist, American Psychological Association Annual Convention, Atlanta, GA, August.
- 1990 “Racial Discrimination in Death Penalty Cases,” Invited presentation, NAACP Legal Defense Fund Conference on Capital Litigation, August, Airlie, VA.
- 1989 “Psychology and Legal Change: The Impact of a Decade,” Invited Address to Division 41 (Psychology and Law), American Psychological Association Annual Convention, New Orleans, LA., August.
- “Judicial Remedies to Pretrial Prejudice,” Law & Society Association Annual Meeting, Madison, WI, June.
- “The Social Psychology of Police Interrogation Techniques” (with R. Liebowitz), Law & Society Association Annual Meeting, Madison, WI, June.
- 1987 “The Fourteenth Amendment and Symbolic Legality: Let Them Eat Due Process,” APA Annual Convention, New York, N.Y. August.
- “The Nature and Function of Prison in the United States and Mexico: A Preliminary Comparison,” InterAmerican Congress of Psychology, Havana, Cuba, July.
- 1986 Chair, Division 41 Invited Address and “Commentary on the Execution Ritual,” APA Annual Convention, Washington, D.C., August.

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“Capital Punishment,” Invited Address, National Association of Criminal Defense Lawyers Annual Convention, Monterey, CA, August.

1985 “The Role of Law in Graduate Social Science Programs” and “Current Directions in Death Qualification Research,” American Society of Criminology, San Diego, CA, November.

“The State of the Prisons: What’s Happened to ‘Justice’ in the ‘70s and ‘80s?” Invited Address to Division 41 (Psychology and Law); APA Annual Convention, Los Angeles, CA, August.

1983 “The Role of Social Science in Death Penalty Litigation.” Invited Address in National College of Criminal Defense Death Penalty Conference, Indianapolis, IN, September.

1982 “Psychology in the Court: Social Science Data and Legal Decision-Making.” Invited Plenary Address, International Conference on Psychology and Law, University College, Swansea, Wales, July.

1982 “Paradigms in Conflict: Contrasting Methods and Styles of Psychology and Law.” Invited Address, Social Science Research Council, Conference on Psychology and Law, Wolfson College, Oxford University, March.

1982 “Law and Psychology: Conflicts in Professional Roles.” Invited paper, Western Psychological Association Annual Meeting, April.

1980 “Using Psychology in Test Case Litigation,” panelist, American Psychological Association Annual Convention, Montreal, Canada, September.

“On the Selection of Capital Juries: The Biasing Effects of Death Qualification.” Paper presented at the Interdisciplinary Conference on Capital Punishment. Georgia State University, Atlanta, GA, April.

Exhibit A

“Diminished Capacity and Imprisonment: The Legal and Psychological Issues,” Proceedings of the American Trial Lawyers Association, Mid-Winter Meeting, January.

1975 “Social Change and the Ideology of Individualism in Psychology and Law.” Paper presented at the Western Psychological Association Annual Meeting, April.

SERVICE TO STAFF OR EDITORIAL BOARDS OF FOUNDATIONS, SCHOLARLY JOURNALS OR PRESSES

2016-present	Editorial Consultant, <u>Translational Issues in Psychological Science</u> .
2015-present	Editorial Consultant, <u>Criminal Justice Review</u> .
2014-present	Editorial Board Member, <u>Law and Social Inquiry</u> .
2013-present	Editorial Consultant, <u>Criminal Justice and Behavior</u> .
2012-present	Editorial Consultant, <u>Law and Society Review</u> .
2011-present	Editorial Consultant, <u>Social Psychological and Personality Science</u> .
2008-present	Editorial Consultant, <u>New England Journal of Medicine</u> .
2007-present	Editorial Board Member, <u>Correctional Mental Health Reporter</u> .
2007-present	Editorial Consultant, <u>Journal of Offender Rehabilitation</u> .
2004-present	Editorial Board Member, American Psychology and Law Society Book Series, Oxford University Press.
2000-2003	Reviewer, Society for the Study of Social Issues Grants-in-Aid Program.
2000-present	Editorial Board Member, <u>ASAP</u> (on-line journal of the Society for the Study of Social Issues)
1997-present	Editorial Board Member (until 2004), Consultant, <u>Psychology, Public Policy, and Law</u>

Exhibit A

1991	Editorial Consultant, Brooks/Cole Publishing
1989	Editorial Consultant, <u>Journal of Personality and Social Psychology</u>
1988-	Editorial Consultant, <u>American Psychologist</u>
1985	Editorial Consultant, <u>American Bar Foundation Research Journal</u>
1985-2006	<u>Law and Human Behavior</u> , Editorial Board Member
1985	Editorial Consultant, Columbia University Press
1985	Editorial Consultant, <u>Law and Social Inquiry</u>
1980-present	Reviewer, National Science Foundation
1997	Reviewer, National Institutes of Mental Health
1980-present	Editorial Consultant, <u>Law and Society Review</u>
1979-1985	Editorial Consultant, <u>Law and Human Behavior</u>
1997-present	Editorial Consultant, <u>Legal and Criminological Psychology</u>
1993-present	<u>Psychology, Public Policy, and Law</u> , Editorial Consultant

GOVERNMENTAL, LEGAL AND CRIMINAL JUSTICE CONSULTING

Training Consultant, Palo Alto Police Department, 1973-1974.

Evaluation Consultant, San Mateo County Sheriff's Department, 1974.

Design and Training Consultant to Napa County Board of Supervisors, County Sheriff's Department (county jail), 1974.

Training Consultation, California Department of Corrections, 1974.

Consultant to California Legislature Select Committee in Criminal Justice, 1974, 1980-1981 (effects of prison conditions, evaluation of proposed prison legislation).

Exhibit A

Reviewer, National Science Foundation (Law and Social Science, Research Applied to National Needs Programs), 1978-present.

Consultant, Santa Clara County Board of Supervisors, 1980 (effects of jail overcrowding, evaluation of county criminal justice policy).

Consultant to Packard Foundation, 1981 (evaluation of inmate counseling and guard training programs at San Quentin and Soledad prisons).

Member, San Francisco Foundation Criminal Justice Task Force, 1980-1982 (corrections expert).

Consultant to NAACP Legal Defense Fund, 1982- present (expert witness, case evaluation, attorney training).

Faculty, National Judicial College, 1980-1983.

Consultant to Public Advocates, Inc., 1983-1986 (public interest litigation).

Consultant to California Child, Youth, Family Coalition, 1981-82 (evaluation of proposed juvenile justice legislation).

Consultant to California Senate Office of Research, 1982 (evaluation of causes and consequences of overcrowding in California Youth Authority facilities).

Consultant, New Mexico State Public Defender, 1980-1983 (investigation of causes of February, 1980 prison riot).

Consultant, California State Supreme Court, 1983 (evaluation of county jail conditions).

Member, California State Bar Committee on Standards in Prisons and Jails, 1983.

Consultant, California Legislature Joint Committee on Prison Construction and Operations, 1985.

Consultant, United States Bureau of Prisons and United States Department of the Interior (Prison History, Conditions of Confinement Exhibition, Alcatraz Island), 1989-1991.

Consultant to United States Department of Justice, 1980-1990 (evaluation of institutional conditions).

Consultant to California Judicial Council (judicial training programs), 2000.

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Consultant to American Bar Association/American Association for Advancement of Science Task Force on Forensic Standards for Scientific Evidence, 2000.

Invited Participant, White House Forum on the Uses of Science and Technology to Improve Crime and Prison Policy, 2000.

Member, Joint Legislative/California Department of Corrections Task Force on Violence, 2001.

Consultant, United States Department of Health & Human Services/Urban Institute, "Effects of Incarceration on Children, Families, and Low-Income Communities" Project, 2002.

Detention Consultant, United States Commission on International Religious Freedom (USCIRF). Evaluation of Immigration and Naturalization Service Detention Facilities, July, 2004-2005.

Consultant, International Committee of the Red Cross, Geneva, Switzerland, Consultant on international conditions of confinement.

Member, Institutional Research External Review Panel, California Department of Corrections, November, 2004-2008.

Consultant, United States Department of Health & Human Services on programs designed to enhance post-prison success and community reintegration, 2006.

Consultant/Witness, U.S. House of Representatives, Judiciary Committee, Evaluation of legislative and budgetary proposals concerning the detention of undocumented persons, February-March, 2005.

Invited Expert Witness to National Commission on Safety and Abuse in America's Prisons (Nicholas Katzenbach, Chair); Newark, New Jersey, July 19-20, 2005.

Testimony to the United States Senate, Judiciary Subcommittee on the Constitution, Civil Rights, and Property Rights (Senators Brownback and Feingold, co-chairs), Hearing on "An Examination of the Death Penalty in the United States," February 7, 2006.

National Council of Crime and Delinquency "Sentencing and Correctional Policy Task Force," member providing written policy recommendations to the California legislature concerning overcrowding crisis in the California Department of Corrections and Rehabilitation.

Trainer/Instructor, Federal Bureau of Prisons and United States Department of Justice, "Correctional Excellence" Program, providing instruction concerning conditions

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of confinement and psychological stresses of living and working in correctional environments to mid-level management corrections professionals, May, 2004-2008.

Invited Expert Witness, California Commission on the Fair Administration of Justice, Public Hearing, Santa Clara University, March 28, 2008.

Invited Participant, Department of Homeland Security, Mental Health Effects of Detention and Isolation, 2010.

Invited Witness, Before the California Assembly Committee on Public Safety, August 23, 2011.

Consultant, "Reforming the Criminal Justice System in the United States" Joint Working Group with Senator James Webb and Congressional Staffs, 2011 Developing National Criminal Justice Commission Legislation.

Invited Participant, United Nations, Forum with United Nations Special Rapporteur on Torture Concerning the Overuse of Solitary Confinement, New York, October, 2011.

Invited Witness, Before United States Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights Hearing on Solitary Confinement, June 19, 2012.

Member, National Academy of Sciences Committee to Study the Causes and Consequences of the High Rate of Incarceration in the United States, 2012-2014.

Member, National Academy of Sciences Briefing Group, briefed media and public officials at Pew Research Center, Congressional staff, and White House staff concerning policy implications of The Growth of Incarceration in the United States: Exploring the Causes and Consequences (2014), April 30-May 1.

Consultant to United States Department of Justice and White House Domestic Policy Council on formulation of federal policy concerning use of segregation confinement, 2015.

PRISON AND JAIL CONDITIONS EVALUATIONS AND LITIGATION

Hoptowit v. Ray [United States District Court, Eastern District of Washington, 1980; 682 F.2d 1237 (9th Cir. 1982)]. Evaluation of psychological effects of conditions of confinement at Washington State Penitentiary at Walla Walla for United States Department of Justice.

Exhibit A

Wilson v. Brown (Marin County Superior Court; September, 1982, Justice Burke). Evaluation of effects of overcrowding on San Quentin mainline inmates.

Thompson v. Enomoto (United States District Court, Northern District of California, Judge Stanley Weigel, 1982 and continuing). Evaluation of conditions of confinement on Condemned Row, San Quentin Prison.

Toussaint v. McCarthy [United States District Court, Northern District of California, Judge Stanley Weigel, 553 F. Supp. 1365 (1983); 722 F. 2d 1490 (9th Cir. 1984) 711 F. Supp. 536 (1989)]. Evaluation of psychological effects of conditions of confinement in lockup units at DVI, Folsom, San Quentin, and Soledad.

In re Priest (Proceeding by special appointment of the California Supreme Court, Judge Spurgeon Avakian, 1983). Evaluation of conditions of confinement in Lake County Jail.

Ruiz v. Estelle [United States District Court, Southern District of Texas, Judge William Justice, 503 F. Supp. 1265 (1980)]. Evaluation of effects of overcrowding in the Texas prison system, 1983-1985.

In re Atascadero State Hospital (Civil Rights of Institutionalized Persons Act of 1980 action). Evaluation of conditions of confinement and nature of patient care at ASH for United States Department of Justice, 1983-1984.

In re Rock (Monterey County Superior Court 1984). Appointed to evaluate conditions of confinement in Soledad State Prison in Soledad, California.

In re Mackey (Sacramento County Superior Court, 1985). Appointed to evaluate conditions of confinement at Folsom State Prison mainline housing units.

Bruscino v. Carlson (United States District Court, Southern District of Illinois 1984 1985). Evaluation of conditions of confinement at the United States Penitentiary at Marion, Illinois [654 F. Supp. 609 (1987); 854 F.2d 162 (7th Cir. 1988)].

Dohner v. McCarthy [United States District Court, Central District of California, 1984-1985; 636 F. Supp. 408 (1985)]. Evaluation of conditions of confinement at California Men's Colony, San Luis Obispo.

Invited Testimony before Joint Legislative Committee on Prison Construction and Operations hearings on the causes and consequences of violence at Folsom Prison, June, 1985.

Exhibit A

Stewart v. Gates [United States District Court, 1987]. Evaluation of conditions of confinement in psychiatric and medical units in Orange County Main Jail, Santa Ana, California.

Duran v. Anaya (United States District Court, 1987-1988). Evaluation of conditions of confinement in the Penitentiary of New Mexico, Santa Fe, New Mexico [Duran v. Anaya, No. 77-721 (D. N.M. July 17, 1980); Duran v. King, No. 77-721 (D. N.M. March 15, 1984)].

Gates v. Deukmejian (United States District Court, Eastern District of California, 1989). Evaluation of conditions of confinement at California Medical Facility, Vacaville, California.

Kozeak v. McCarthy (San Bernardino Superior Court, 1990). Evaluation of conditions of confinement at California Institution for Women, Frontera, California.

Coleman v. Gomez (United States District Court, Eastern District of California, 1992-3; Magistrate Moulds, Chief Judge Lawrence Karlton, 912 F. Supp. 1282 (1995). Evaluation of study of quality of mental health care in California prison system, special mental health needs at Pelican Bay State Prison.

Madrid v. Gomez (United States District Court, Northern District of California, 1993, District Judge Thelton Henderson, 889 F. Supp. 1146 (N.D. Cal. 1995). Evaluation of conditions of confinement and psychological consequences of isolation in Security Housing Unit at Pelican Bay State Prison, Crescent City, California.

Clark v. Wilson, (United States District Court, Northern District of California, 1998, District Judge Fern Smith, No. C-96-1486 FMS), evaluation of screening procedures to identify and treatment of developmentally disabled prisoners in California Department of Corrections.

Turay v. Seling [United States District Court, Western District of Washington (1998)]. Evaluation of Conditions of Confinement-Related Issues in Special Commitment Center at McNeil Island Correctional Center.

In re: The Commitment of Durden, Jackson, Leach, & Wilson. [Circuit Court, Palm Beach County, Florida (1999).] Evaluation of Conditions of Confinement in Martin Treatment Facility.

Ruiz v. Johnson [United States District Court, Southern District of Texas, District Judge William Wayne Justice, 37 F. Supp. 2d 855 (SD Texas 1999)]. Evaluation of current conditions of confinement, especially in security housing or "high security" units.

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Osterback v. Moore (United States District Court, Southern District of Florida (97-2806-CIV-MORENO) (2001) [see, Osterback v. Moore, 531 U.S. 1172 (2001)]. Evaluation of Close Management Units and Conditions in the Florida Department of Corrections.

Valdivia v. Davis (United States District Court, Eastern District of California, 2002). Evaluation of due process protections afforded mentally ill and developmentally disabled parolees in parole revocation process.

Ayers v. Perry (United States District Court, New Mexico, 2003). Evaluation of conditions of confinement and mental health services in New Mexico Department of Corrections “special controls facilities.”

Disability Law Center v. Massachusetts Department of Corrections (Federal District Court, Massachusetts, 2007). Evaluation of conditions of confinement and treatment of mentally ill prisoners in disciplinary lockup and segregation units.

Plata/Coleman v. Schwarzenegger (Ninth Circuit Court of Appeals, Three-Judge Panel, 2008). Evaluation of conditions of confinement, effects of overcrowding on provision of medical and mental health care in California Department of Corrections and Rehabilitation. [See Brown v. Plata, 563 U.S. 493 (2011).]

Ashker v. Brown (United States District Court, Northern District of California, 2013-2015). Evaluation of the effect of long-term isolated confinement in Pelican Bay State Prison Security Housing Unit.

Parsons v. Ryan (United States District Court, District of Arizona, 2012-14). Evaluation of conditions of segregated confinement for mentally ill and non-mentally ill prisoners in statewide correctional facilities. [See Parsons v. Ryan, 754 F.3d 657 (9th Cir. 2014)].

Braggs v. Dunn (United States District Court, Middle District of Alabama, 2015-2017). Evaluation of mental health care delivery system, overcrowded conditions of confinement, and use of segregation in statewide prison system. [See Braggs v. Dunn, 257 F. Supp. 3d 1171 (M.D. Ala. 2017).]

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EXHIBIT B

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Index:

Provided June 23, 2020

- April 10, 2020 Pandemic Response Requirements
- June 23, 2020 Pandemic Response Requirements

Provided June 22, 2020

- Declaration of Oscar Manuel Perez Aguirre
- CDC Guidelines
 - CDC Interim Guidelines FAQ (June 2020)
 - CDC Interim Guidelines Pamphlet (March 30, 2020)
 - CDC Interim Guidelines Main (March 23, 2020)

Provided June 4, 2020

- Declaration of Plaintiff Ruben Mencias Soto
- Letter from SPLC to Pine Prairie ICE Processing Center
- CBS News: Experts Worry About Effects of Coronavirus Pandemic on Those with Mental Health Issues
- ICE Production on Mental Illness
- Journal on Korean Medical Science – *Report on the Epidemiological Features of Coronavirus Disease 2019 (COVID-19) Outbreak in the Republic of Korea from January 19 to March 2, 2020*
- KFF: *The Implications of COVID-19 for Mental Health and Substance Use*
- Maryland General Health: *FAQs about Mental Health and COVID-19*
- Mass General: *Specific Mental Health Conditions (COVID-19)*
- NCBI: *Impact of COVID-19 Pandemic on Pre-Existing Mental Health Problems*

Exhibit B

- Memo: Psychiatric Illness and COVID-19
- The Lancet Psychiatry: *Patients with Mental Health Disorders in the COVID-19 Pandemic*

Provided June 9, 2020

- Declaration of Plaintiff Alex Hernandez (March 25, 2020)
- Declaration of Plaintiff Alex Hernandez (April 10, 2020)
- ICE's COVID-19 Pandemic Response Requirements (April 10, 2020)
- LA Times: *ICE Said a 74-year-old was Too Dangerous to Release. He Died of Apparent Suicide.*
- Washington Examiner: *Elderly ICE Detainee Seeking Release to Avoid Coronavirus Dies by Suicide*

Provided March 11, 2020

- Disability Rights California, *There is No Safety Here* (March 2017)
- Office of Inspector General, Office of Homeland Security, OIG-16-113-VR: *Ice Still Struggles to Hire and Retain Staff for Mental Health Cases in Immigration Detention* (July 2016)
- Office of Inspector General, Office of Homeland Security, OIG-11-62: *Management of Mental Health Cases in Immigration Detention* (March 2011)

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15 Attorneys for Plaintiffs (continued on next page)

16 **UNITED STATES DISTRICT COURT**
17 **CENTRAL DISTRICT OF CALIFORNIA**
18 **EASTERN DIVISION – RIVERSIDE**

19 FAOUR ABDALLAH FRAIHAT, *et al.*,
20 Plaintiffs,

21 v.

22 U.S. IMMIGRATION AND CUSTOMS
23 ENFORCEMENT, *et al.*,

24 Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF FAVIO
NAVARRO GARCIA**

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27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF FAVIO NAVARRO GARCIA

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

1. I am at least 18 years of age and am competent to make this declaration.
2. My full name is Favio Navarro Garcia. I am 58 years old. I am currently detained by ICE in the Catahoula Correctional Center in Louisiana. I have been at Catahoula since early April 2020. I was previously detained in a detention center in Minnesota and transferred to Catahoula.
3. About two weeks after I arrived in Catahoula, I began to feel chills, body aches, and feverish. I was living in C dorm at the time. I sent in a written request for medical attention but after two days without a response, another detained person who speaks English helped me ask a security guard for help.
4. I was in C dorm for two days after I reported my symptoms, and then I was moved to E dorm. It seems to me that E is where they move everyone who starts feeling bad. In E dorm, I got a COVID-19 test, as did everyone else in the dorm. We were in E dorm for two more days, I believe waiting for the results to come back. I had almost no information from Catahoula staff about why I was moved or what was happening with my test results.
5. I was then moved into I dorm. I think I was taken to I dorm because my test results came back positive, although I did not find out that I had tested positive until my pro bono attorney called and got my medical records in early June 2020.
6. In I dorm nurses started taking my temperature three times a day. I had never had my temperature taken prior to moving to I dorm. They also checked my blood pressure and oxygen levels. The nurses wore protective equipment. While in dorms I and E, I was given a mask.
7. Dorms C, E, and I were all open dorms. There were approximately 80 other people in I dorm with me. Most of the dorm was occupied before I was

1 moved into I dorm. I stayed in I dorm for approximately 15 days. I did not
2 get any information from Catahoula staff, but I believe I was in I dorm in
3 order to be quarantined. I saw many of the people who were in I dorm with
4 me be moved to other dorms while I was still doing my quarantine.

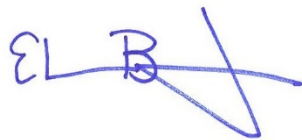
5 8. In I dorm, it was impossible to social distance. The detained people did all of
6 the cleaning in the dorm except sometimes the guards cleaned the phones.

7 9. I have seen a doctor twice since I was moved out of I dorm. Both times, I
8 requested the appointments because I felt chest pains and headaches. In my
9 current dorm, they sometimes take our temperature. I always go to get mine
10 checked to see how I'm doing.

11 10. As of today I feel better. However, about two weeks ago, they used pepper
12 spray on some other detained people. Because I was close by using the
13 telephone, I also breathed in the spray, and it made breathing more difficult.
14 I am still worried about the other people here at Catahoula and whether they
15 will get sick.

16 I declare under penalty of perjury that the statements above are true and correct to
17 the best of my knowledge. I have given attorney Elizabeth Jordan permission to
18 sign this declaration on my behalf due to the pandemic.
19

20 Signature:

21 A handwritten signature in blue ink, appearing to be 'ELB' followed by a stylized flourish.

Elizabeth Jordan on behalf of Favio

Navarro Garcia

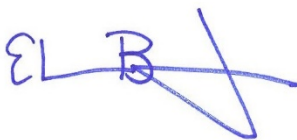
Date: 6/22/2020

Location: Catahoula Parish, Louisiana

1 I, Elizabeth Jordan, declare the following under penalty of perjury pursuant to 28
2 U.S.C. § 1746 as follows:

- 3 1. I am a licensed attorney in good standing in Louisiana and New York. I am
4 an attorney of record in *Frailhat v. ICE*, Case 5:19-cv-01546 (C.D. Cal.).
- 5 2. Out of necessity in light of the COVID-19 pandemic, I signed the attached
6 declaration on Favio Navarro Garcia's behalf with his express consent.
- 7 3. ICE is requiring legal visitors to provide and wear personal protective
8 equipment, including disposable vinyl gloves, surgical masks, and eye
9 protection while visiting any detention facility. It is extremely difficult to
10 arrange an in-person legal visit while this policy is in effect. The policy has
11 not been updated since April 2, 2020
- 12 4. Travel is still discouraged by the CDC. Mr. Navarro Garcia is detained in
13 Louisiana and I live in Denver, Colorado. Further, I am at high risk for
14 COVID-19 infection and complications. To protect both my and public
15 health, I am not able to obtain Mr. Navarro Garcia's signature.
- 16 5. I spoke with Mr. Navarro Garcia over the phone. While we were speaking, I
17 simultaneously translated the declaration into Spanish for Mr. Navarro
18 Garcia's review for accuracy, confirmation of the contents, and approval. I
19 am a non-native fluent Spanish speaker. Mr. Navarro Garcia has confirmed
20 that I can sign on his behalf as reflected in his declaration.

21 I declare under penalty of perjury that the statements above are true and correct to
22 the best of my knowledge and that this declaration was executed on June 22, 2020
23 in Denver, Colorado.
24

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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,

Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**THIRD SUPPLEMENTAL
DECLARATION OF DR. HOMER
VENTERS**

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*Admitted Pro Hac Vice

**Pro Hac Vice Application Forthcoming

THIRD SUPPLEMENTAL DECLARATION OF DR. HOMER VENTERS

I, Homer Venters, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Homer Venters. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. I have previously submitted three declarations in this case in connection with Plaintiffs' Motion for Preliminary Injunction. *See* ECF 81-11, 113-2, 127-3. My extensive background in correctional medicine is detailed in my first declaration and in my curriculum vitae attached thereto. ECF 81-11.
2. Since the onset of the COVID-19 pandemic, in addition to my work on this case, I have been involved in numerous cases evaluating COVID-19 responses in prisons, jails and immigration detention centers.
3. In connection with my work, I am closely and carefully evaluating best practices and clinical guidance concerning treatment of and detention facility responses to COVID-19, including review of new peer-reviewed publications and local, state and national guidelines and recommendations regarding COVID-19 response in congregate care settings including detention facilities. I am in close and frequent contact with epidemiologists, public health experts, and other medical providers to discuss and assess medically necessary responses to COVID-19. I have been asked to provide input regarding appropriate COVID-19 responses in correctional settings by the National Academy of Sciences, the American Medical Association, The National Association of Counties, Harvard University and other organizations seeking to promote evidence-based COVID-19 care for people with justice involvement.
4. I have carefully monitored ICE's response to COVID-19. I have carefully reviewed ICE's Pandemic Response Requirements (PRR) (including its June 22 revisions), the declarations attached to Plaintiff's motion, ICE's document productions in this case, and have other knowledge of ICE's response to COVID-19 through my independent research and work in other cases across country.
5. Based on my expert opinion, ICE's response to COVID-19 continues to

1 place people in its custody—particularly medically vulnerable people—at a
2 substantial risk of serious harm and even death. In this declaration, I
3 highlight some of the most dangerous aspects of ICE’s ongoing COVID-19
4 response that should be remediated immediately.

5 **Lack of Special Protections for People with Risk Factors**

6 6. Based on my review of current practices and policies of ICE, including the
7 revised PRR issued on June 22, 2020, it appears that no additional
8 meaningful steps have been taken to create heightened protections for people
9 who are at high-risk of serious illness or death from COVID-19. Detention
10 creates special risks for high-risk detainees that have not been addressed by
11 ICE. To provide but one example, high-risk detainees are often placed into
12 close contact with other detainees when receiving their medications, e.g.,
13 while waiting in ‘pill-lines.’ These lines routinely have detainees with high-
14 risk conditions standing shoulder to shoulder with other detainees. Similarly,
15 many high-risk detainees share very crowded congregate bathroom settings
16 without partitions or share a cell with a common toilet. Both types of
17 settings create repeated exposure to the fecal plume that disperses into the air
18 every time a toilet is flushed, creating a potent vector for transmission of
19 COVID-19 to high-risk patients. The primary vector for COVID-19
20 infections continues to be staff, who come and go to facilities every day, and
21 I continue to review reports from detainees that staff have stopped wearing
22 masks unless a supervisor is present, especially in housing areas in evenings
23 and over weekends. In addition, basic cleaning and disinfecting efforts
24 appear to be counterproductive in some settings where ICE is utilizing
25 agents that cause irritation of the eyes, nose and mouth of detainees and
26 where the cleaning process is done in close proximity to detainees and where
27 detainees conducting the cleaning or disinfecting may lack basic training or
28 PPE. Although cleaning and disinfecting is a crucial component of infection
control measures, ICE must ensure that people are not exposed to them since
they can cause health issues, such as respiratory issues, that further place
people at risk of COVID-19. Use of these harsh disinfectants in close
proximity to detained people—especially medically vulnerable people—
poses potentially grave danger.

7. These inherent and ongoing risks are merely illustrative of significant other
risks of harm threatening medically vulnerable people.¹ The easiest method
of protecting people with Risk Factors is simply to release them. While

¹ Below I address in greater detail additional deficiencies in ICE’s overall
response, including its revised PRR, that further places medically vulnerable
people at risk.

1 release is a primary method to reduce the risks posed by COVID-19 for
2 high-risk detainees, there are numerous other interventions that are required
3 to reduce risk for this same cohort while detained. The types of protections
4 that can make a meaningful reduction in the risk of serious illness or death
5 from COVID-19 include the following:

- 6 a. Twice daily screening of symptoms and temperature consistent with
7 CDC recommendations using a structured screening tool;²
- 8 b. Cohorting of high-risk detainees into specialized housing areas with
9 enhanced infection control measures and training among staff, who
10 are steady on these units;
- 11 c. Healthcare evaluations by appropriately trained staff to assess high-
12 risk patients' current conditions, symptoms, medications, and to make
13 a plan for COVID-19 infection;
- 14 d. Enhanced medical monitoring of medically vulnerable people when
15 they have COVID-19, as well as treatment protocols;
- 16 e. Standards and protocols to ensure that medically vulnerable people
17 are properly evaluated following their recovery from COVID-19;
- 18 f. Increased social distancing measures and PPE for high-risk people;
- 19 g. Increased medical surveillance of people with Risk Factors, including
20 contact tracing;
- 21 h. Expansion of testing to people with Risk Factors and close
22 contacts/staff;
- 23 i. Prohibitions on transfer (because transfer risks spread);
- 24 j. Clear guidance on how requisite conditions of medical isolation and
25 quarantine to ensure that conditions equivalent to solitary confinement
26 are not imposed;
- 27 k. Enhanced cleaning measures for areas occupied by medically
28 vulnerable people (and standards to ensure that people are not exposed
to harsh cleaning agents _;
- l. Increased education of people with Risk Factors;
- m. Enhanced training of staff with any responsibility over people with
Risk Factors;
- n. Audits of medical staffing ratios at facilities to ensure proper staffing
where medically vulnerable people are detained;
- o. Hospitalization protocols for people with Risk Factors;

8. Currently, the PRR fails to prescribe these basic precautionary measures that
are crucial to the health and safety of medically vulnerable people. In

² Temperature checks alone are inadequate because many people with COVID-19
do not have a fever and thermometers may be wrong. Symptom checks are an
important component of screening and should be done in conjunction with
temperature checks.

1 addition to these necessary precautionary measures, below I elaborate on
2 some of the crucial safeguards that should be implemented to protect
3 people—especially medically vulnerable people—in ICE’s care but that are
4 not addressed in the revised PRR.

5 **Need for Restriction of Transfers**

6 9. Based on reports from throughout the country, ICE unnecessarily continues
7 to transfer large numbers of people between detention facilities and between
8 prisons/jails and detention facilities. This ongoing practice contradicts CDC
9 guidance and places detained people as well as staff at substantial risk of
10 infection and death.

11 10. Detained individuals continue being transferred daily without universal
12 testing. For example, on June 16, 2020, the Director of Farmville confirmed
13 that 34 people who had been recently transferred to Farmville tested positive
14 for COVID-19 upon arrival. Feldman Decl. ¶ 27. This was not an isolated
15 incident, as transfers are occurring in and out of detention facilities
16 systemwide. *See* Doubossarskaia Decl. ¶ 34 (reports individuals being
17 transferred to and from IAH, Conroe, and South Louisiana); *See* Vosburgh
18 Decl. ¶ 17 (reports 30 individuals transferred to ICE custody at Etowah
19 within the last 2 weeks). One who tested positive for COVID-19 after his
20 transfer to Pulaski, a detention center in Chicago, describes being transferred
21 in a small, enclosed van without PEE and with multiple detained noncitizens
22 who were coughing and exhibiting other symptoms of COVID-19. *See*
23 Zwick Decl. ¶ 32. On June 10, 2020, 50 people were reportedly transferred
24 from Broward Transitional Center to Georgia, only to be brought back to
25 Miami, and then finally flown to Louisiana. In fact, a few of those 50
26 individuals were eventually brought back to BTC two days later. *See* King
27 Decl. ¶ 16. One detained individual has been transferred a shocking total of
28 18 times since April 13. *Id.* ¶ 19. These stories of “circular” transfers are not
limited to Florida. Detained individuals in Louisiana report being
transported from the facility to the airport for deportation, and when their
country of origin refuses to accept them, they are brought back to the facility
and placed in general population. Page Decl. ¶ 16.

11. Transfer of detainees in and out of ICE facilities represents a significant
potential source of COVID-19 infection for staff and detained people alike.
Indeed, the CDC has identified detainee transfers as a significant risk for the
spread of infection.³ Increased transfers pose a special risk of infection for

³ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf>.

1 medically vulnerable individuals. Accordingly, the CDC has emphasized
2 that transfers of detained people must be restricted to abate the spread of
3 COVID-19 and should only be used when necessary for medical evaluation,
4 medical isolation/quarantine, clinical care, extenuating security concerns, or
5 to prevent overcrowding.⁴ Notably, however, ICE could achieve many of
6 these goals, e.g., preventing overcrowding and medical isolation/quarantine,
7 simply by releasing people rather than transferring them.

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12. Since the onset of COVID-19, ICE's unnecessary transfer of individuals between facilities has resulted in the preventable spread of the virus between facilities. Indeed, Dr. Scott Allen, who serves as a medical subject matter expert for the Department of Homeland Security, recently observed that "[t]here have been multiple examples of ICE's active transfer of detainees being a source of spread of the virus, causing outbreaks in detention facilities."⁵ The spread of COVID-19 from transfers is highly foreseeable given that ICE systemically fails to test people prior to transfer.⁶

⁴ CDC at 9 <https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf>.

⁵ See Written Statement of Dr. Scott A. Allen, MD, U.S. Senate Committee on the Judiciary, *Examining Best Practices for Incarceration and Detention During COVID-19* (June 2, 2020), <https://www.judiciary.senate.gov/imo/media/doc/Scott%20Allen%20Testimony.pdf> (citing Lisa Riordan Seville and Hannah Rappleye, "ICE keeps transferring detainees around the country, leading to COVID-19 outbreaks," NBC News (May 31, 2020), available at <https://www.nbcnews.com/politics/immigration/ice-keeps-transferring-detainees-around-country-leading-covid-19-outbreaks-n1212856>; Hamed Aleaziz, "ICE Moved Dozens Of Detainees Across the Country During the Coronavirus Pandemic. Now Many Have COVID-19," BuzzFeed News (April 29, 2020), available at <https://www.buzzfeednews.com/article/hamedaleaziz/ice-immigrant-transfer-jail-coronavirus>; Yeganeh Torbati, Dara Lind and Jack Gillum, "In a 10-Day Span, ICE Flew This Detainee Across the Country — Nine Times," ProPublica (March 27, 2020), available at <https://www.propublica.org/article/coronavirus-ice-flights-detaineesirous-asgari>; Monique Maden, "Coronavirus cases skyrocket at ICE detention center in Broward after transfer from Miami," Miami Herald (May 19, 2020), available at <https://www.miamiherald.com/news/local/immigration/article242844451.html>.)

⁶ "During a June 10 Senate Judiciary Committee oversight hearing on COVID-19 in ICE and Bureau of Prisons facilities, Executive Associate Director of Enforcement and Removal Operations Henry Lucero stated that the agency does not conduct universal testing of COVID-19 during transfers, but is considering expanding testing in relation to transfers." *COVID-19 IN ICE CUSTODY Biweekly Analysis & Update* FREEDOMFORIMMIGRANTS (June 18, 2020) at 2 <https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/5eebc846c4275f35d9c6c110/1592510535009/FFI+June+18+COVID-19+update.pdf>.

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13. There are several approaches that ICE should implement in order to mitigate the risk of spreading COVID-19 between facilities, and from one region or state of the U.S to another. First, while it is true that the CDC contemplates that transfer can be utilized as a last resort to effectuate certain needs (e.g., for quarantining and overcrowding), the safest thing for ICE to do to achieve those actions is simply to release people rather than transfer them between facilities. For example, release would permit ICE to reduce detention facility populations to mitigate spread without incurring the significant risk of cross-contamination between facilities as a result of transfer. Likewise, release would permit people to self-quarantine at a home or with a sponsor without increasing the probability of spread via transfer. From both a public health perspective and an institutional management perspective, releases are absolutely safer than transfer not only for detained people but also for facility staff who undergo substantial risk of infection during transfer.
14. Second, any facility with active COVID-19 cases (including people in medical isolation or quarantine) should halt inter-facility transfers into and out of the facility until a 14 day period has passed since the last medical isolation or quarantine has ended. Importantly, in order to ensure that there are no additional positive cases during this period, mass testing and symptom checks are crucial. Third, each facility should maintain a new admission roster that ensures that every newly admitted detainees will be held in a quarantined housing area, without contact with other detainees, for a full 14-day period. New admission quarantine, as well as other forms of medical quarantine, should not be administered as solitary confinement (isolation inside a cell for 22 or more hours per day with material deprivations). The purpose of quarantine, as described by the CDC, is to ensure that people with a potential exposure to COVID-19 are kept physically apart from other people who are not suspected of having the same exposure. Thus, the objective is to maintain a physical separation of the quarantine cohort from other detained people for the duration of 14 days or until the concern for potential exposure has been eliminated. During quarantine, all detainees should be screened at least once per day (but preferably more) for symptoms and signs of COVID-19 and these screenings should not rely solely on temperature checks because people with COVID symptoms often have symptoms other than fever.
15. A structured screening tool, with symptoms of COVID-19, as well as temperature, should be utilized to check newly admitted people for potential COVID-19 at least once daily. During this period, the chronic health problems of every newly admitted detainee should be assessed and a

COVID-19 plan should be created in their medical record, identifying any clinical issues that elevate their risk of serious illness or death from COVID-19, and what measures will be taken to create protections or increased surveillance. The new admission housing period can be shorter when newly arrived detainees are offered testing on days 4-7 and test negative. This same tool should be utilized to conduct twice daily screenings of all high-risk detainees. A COVID-19 plan must also be created for all medically vulnerable people currently in detention (and not just new admissions).

16. In the event that transfers are absolutely necessary, any detained person who is being considered for transfer to another facility or release should similarly be offered testing. No person with a positive test result should be transferred. If the test is negative but the detainee reports symptoms of COVID, then the detainee likewise should not be transferred and an additional test should be administered to rule out false negatives, which are frequent. No individual should be transferred until and unless they test negative for COVID-19. Further, between the time of testing and transfer, precautions must be made to ensure that transmission does not occur within the window between testing and results, but those precautions must not include imposition of conditions equivalent to solitary confinement. Because transfers of ICE detainees are often conducted to accommodate overcrowding, release of detainees will be critical to reducing inter-facility transfers and spread of COVID-19.
17. Although ICE's PRR provides that transfers should be limited only to the circumstances prescribed by the CDC "where possible," the declarations of legal service providers and detainees demonstrates that ICE is not ensuring that unnecessary transfers are not occurring. The revised PRR fails to provide additional protections to ensure that transfers are not limited, thereby further magnifying the risk of infection to medically vulnerable people.

Need for Expanded Testing

18. To date, ICE has conducted only 8,858 tests for a total population of 24,041. This represents only about one third of the detained population. The overall lack of testing by ICE, combined with the fact that many people show no or few symptoms, means that the current number of infected detainees are likely just a small fraction of overall positive cases. As a result, ICE's meager testing numbers threaten to further spread the virus and also to prevent people who are positive from obtaining necessary medical attention before complications occur. Indeed, failure to expand testing increases the

1 likelihood that asymptomatic individuals who are not tested will transmit the
2 virus to medically vulnerable people.⁷ In order to protect medically
3 vulnerable people, ICE's revisions to the PRR should have mandated
4 universal and ongoing testing.⁸

5 19. Declarations of providers and detained individuals show that testing remains
6 inadequate throughout the country. For example, at ICA Farmville, over 100
7 detained individuals participated in a hunger strike, in part, to demand
8 testing symptomatic people. Feldman Decl. ¶ 31. At Pulaski, an individual
9 had to wait 13 days after demonstrating symptoms such as severe chest pain
10 to get tested. Zwick Decl. ¶ 21. According to service providers from NIJC,
11 who represent individuals in detention centers across the country, very little
12 testing has been conducted, "even if detained individuals report having
13 symptoms of COVID-19 and specifically request to be tested." *Id.* at ¶ 31.
14 Indeed, in some instances, ICE has placed people in punitive segregation
15 following a return from the hospital but did not test them for COVID-19.
16 *See, e.g.,* Mencias-Soto Decl. ¶¶ 7, 14 (Adelanto, California). And although
17 ICE should be testing all detained individuals, and not just those exhibiting
18 symptoms, in many facilities, ICE is not regularly checking people for
19 symptoms. Rios Decl. Ex. C ¶ 14. These examples demonstrate that ICE's
20 testing continues to be deficient, thereby exposing medically vulnerable
21 people to avoidable infection.

22 20. ICE should follow the lead of many large State and Federal Prisons as well
23 State and national public health agencies and dramatically expand COVID-
24 19 testing. For example, as of June 22, 2020, the Federal Bureau of Prisons
25 had tested over 19,000 detainees, whereas ICE had tested less than 9,000

26 ⁷ *See, e.g.,* See D. Sutton, K. Fuchs, M. D'Alton, D. Goffman, Universal screening
27 for SARS-CoV-2 in women admitted for delivery N ENGL J MED, (May 28, 2020),
28 pp. 2163-2164, <https://www.nejm.org/doi/full/10.1056/NEJMc2009316> (87% of
all patients who tested positive had no symptoms of COVID-19 upon entry. "The
potential benefits of a universal testing approach include the ability to use Covid-
19 status to determine hospital isolation practices and bed assignments... guide the
use of personal protective equipment); *see also* Dr. Eduardo Sanchez, *COVID-19*
Science: Why Testing is so Important, HEART.ORG (April 2, 2020)
[https://www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-](https://www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-important)
[important](https://www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-important).

⁸ *A Systematic Approach To Mitigate The Spread Of COVID-19 In Immigration*
Detention Facilities HEALTHAFFAIRS (June 17, 2020)
https://www.healthaffairs.org/doi/10.1377/hblog20200616.357449/full/?utm_medium=social&utm_source=twitter&utm_campaign=blog&utm_content=erfani&
(urging ICE to increase COVID-19 screening and mass testing).

1 detainees.⁹ It is critical to recognize that expansion of testing does not
2 represent a one-time testing of many or all detainees, but an expansion of
3 *ongoing* testing until the prevalence of COVID-19, as well as the positivity
4 of tests, is low. Because of the numerous transfers between ICE facilities up
5 to this point, every ICE detainee in custody should be offered COVID-19
6 testing. ICE has taken this approach in two facilities where cases of COVID-
7 19 have been reported, but the ongoing transfer of detainees in between ICE
8 facilities has created a situation that limits the value of expanded testing in
9 limited facilities.¹⁰

- 10 21. CDC guidance on the need for expanded COVID-19 testing in congregate
11 settings, including prisons, makes clear that the approach to testing should
12 be linked to the overall infection control plan. In the case of ICE, the
13 repeated and ongoing practice of transferring detainees around their network
14 of facilities represents a departure from CDC and basic infection control
15 guidance. As a result, the ICE approach to testing must necessarily be
16 as broad and inclusive as possible, involving an initial offer of testing for
17 each detained person, together with subsequent testing based on specific
18 criteria.
- 19 22. In addition, there are multiple other circumstances under which testing
20 should be implemented.
- 21 23. Updated guidelines from the CDC make it clear that ICE must expand
22 ongoing testing for COVID-19 among detained people to prevent new
23 outbreaks in individual facilities. CDC guidance lists people who are at high
24 priority for testing, including “[r]esidents in long-term care facilities or other
25 congregate living settings, including prisons and shelters, **with** symptoms.”¹¹
26 This includes all ICE detainees and thus, ICE must establish a mechanism to
27 screen every detainee on a daily basis for symptoms of COVID-19, as well
28 as respond to detainees with one or more symptoms or sign of COVID-19
with testing. While some facilities may conduct temperature checks, the
practice of only checking the temperatures of detainees as a means to detect
COVID-19 infections is not supported by the CDC and a recent assessment
of the infrared noncontact type of thermometers being used in many ICE
facilities revealed concerns about consistently low temperature readings.

⁹ Compare <https://www.bop.gov/coronavirus/> with
<https://www.ice.gov/coronavirus> (last visited June 22, 2020).

¹⁰ <https://www.ice.gov/news/releases/ice-offers-voluntary-covid-19-testing-all-detainees-2-facilities#wcm-survey-target-id>

¹¹ <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

1 Indeed, through my work, I have observed systematic lower readings in
2 detention settings.

3 24. Beyond testing of symptomatic individuals, ICE should decide whether a
4 new positive COVID-19 test in a facility will result in testing (or re-testing)
5 the entire facility or simply close contacts of the new case. CDC guidelines
6 state that to slow the spread of COVID-19 in nursing homes, new cases
7 should result in testing of either the entire facility, or in cases where testing
8 supplies are limited, all close contacts of the new case.¹² The more limited
9 approach, only testing close contacts of an index COVID-19 case, may
10 prove more difficult for ICE since it requires a commitment to contact
11 tracing utilizing trained staff and utilizing the core principles identified by
12 the CDC.¹³ The plan for testing, including these decisions, should be
13 identified for every facility, along with quality assurance metrics. Simply
14 providing universal ongoing testing will likely obviate some of the logistical
15 hurdles of limiting testing on the basis of contact tracing.

16 25. Because COVID-19 testing may cause apprehension about the implications
17 of testing for a detained person's immigration or detention status, health
18 staff must ensure that COVID-19 testing is explained and offered in the
19 language of the detained patient's choosing and that patients are informed
20 that the decision to accept a COVID-19 test is unrelated to their immigration
21 or detention status. The most effective way to promote acceptance of testing,
22 as well as other basic COVID-19 measures in the CDC guidelines, is to
23 establish a weekly COVID-19 briefing for each housing area by a health
24 professional, both to answer questions and explain priorities for preventing,
25 detecting and treating COVID-19. In my experience managing outbreaks in
26 detention settings, this approach has proved to be extremely valuable for
27 both the functioning of the health service and engagement of patients. The
28 revised PRR lacks such measures.

29 26. I am aware of detained people reporting that swab samples are collected by
30 non-health staff and that the techniques utilized do not appear to be
31 standardized, including nasal swabs of the outside of the nose or very
32 proximal area of the nostril. Health staff should be conducting these tests
33 and a standard amount of training should be ensured and monitored. Part of
34 this testing must include informing all detainees of the results of their tests
35 withing 24 hours of the test results becoming available.

36 ¹² <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

37 ¹³ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf>

1
2 27. An additional issue for ICE is whether tests have already been performed
3 using tests with unacceptably high false-negative rates such as the Abbott ID
4 Now test. The standard of care in correctional and community settings is to
5 conduct confirmatory testing, meaning that original samples that run with
6 this test are re-tested with another, more reliable test. ICE should know how
7 many of these Abbott ID Now tests have been conducted, how many still are
8 awaiting confirmatory testing, and what the concordance rate was, especially
9 any instances of apparent false-negative tests.

10 28. ICE should also offer testing to anyone newly arrived to a facility as well as
11 anyone before they leave a facility, whether for release to the community,
12 removal to another country, or transfer to another facility. Concerningly, at a
13 recent Senate Judiciary Hearing, ICE recently admitted that it not testing
14 most people prior to removal, which places people at a particularly high risk
15 of severe illness and death.¹⁴ Here, too, the revised PRR is deficient.

16 **Medical Isolation and Quarantine Should Not Result in Solitary Confinement**

17 29. Reports also show that ICE is utilizing the dangerous practice of placing
18 individuals in conditions equivalent to punitive solitary confinement in order
19 to quarantine them or to place them in medical isolation. Such practices are
20 extremely dangerous and increase the likelihood of spread, severe illness and
21 death.

22 30. The evidence shows that ICE is imposing conditions equivalent to solitary
23 confinement as part of its COVID-19 response across the country. *See*
24 Zwick Decl. ¶¶ 40-41; Dobbins Decl. ¶ 15; Page Decl. ¶ 15, Rios Decl. ¶ 19;
25 Aguirre Decl. ¶¶ 8-10; Saenz Decl. ¶ 6; Vosburgh Decl. ¶¶ 14-15, 21;
26 Doubossarskaia Decl. ¶ 35. ICE is imposing these conditions on people who
27 are positive for COVID-19 as a means of medical isolation, *see, e.g.*, Page
28 Decl. ¶ 15, as well as a method of quarantining non-positive cases, *see, e.g.*,
Saenz Decl. ¶ 6; Dobbins Decl. ¶ 15. Given that it is well known that solitary
confinement is dangerous, it is not surprising that these practices have had
the dangerous result of causing people's mental and physical deterioration.
See, e.g., Saenz Decl. ¶ 6; Doubossarskaia Decl. ¶ 35.

31. The CDC recommends medical isolation and use of quarantining in certain
circumstances, e.g., as a means of isolating positive cases or preventing

¹⁴ Monique O Madan, *ICE admits to transferring detainees with COVID-19, says it can't test everybody* MIAMIHERALD (May 28, 2020), <https://www.miamiherald.com/news/local/immigration/article243031176.html>.

1 spread. However, the CDC does not recommend the use of solitary
2 confinement. Solitary confinement is distinct from medical isolation and
3 quarantining in significant ways.¹⁵ Solitary confinement generally involves
4 extended lockdown of a person (22+ hours/day) with severe material
deprivations, lack of contact, and oversight by security personnel.

5 32. By contrast, medical isolation and quarantine do not involve such
6 deprivations. There is nothing about either medical isolation or quarantine
7 that demands that people in those settings be deprived material needs, such
8 as television, reading material, showers/bathroom, and access to telephones
9 or video teleconferencing in order to communicate with loved ones and
10 advocates. Likewise, access to the outdoors should be a part of both medical
11 isolation and quarantine in order to help abate the risk of harm stemming
12 from prolonged isolation in a room. Further, medical isolation and
13 quarantine require oversight by medical and mental health staff—not
security staff. This is especially true of medical isolation of confirmed or
suspected cases of COVID-19 because people can deteriorate extremely
quickly and therefore should be easily observable by medical/mental health
staff.

14 33. The imposition of conditions equivalent to solitary confinement also will
15 deter people from reporting symptoms—which will increase the likelihood
16 of spread and complications from COVID-19. ICE must address the fear
17 among detainees that reporting symptoms of COVID-19 or testing positive
for COVID-19 will result in their punishment.

18 34. Moreover, there is no doubt that placement into a cell designed for solitary
19 confinement for 23 or 24 hours per day represents a psychological stressor
20 and threat to mental health. For example, Mr. Aguirre reports that he was
21 placed into the solitary confinement unit of his facility in Colorado, and that
22 he experienced psychological stress from this setting, without any mental
23 health screening or care. Aguirre Decl. ¶¶ 9-10.

24 35. It is possible to implement medical isolation and quarantine without all of
25 the punitive aspects of solitary confinement, but this requires a commitment
26 of resources and monitoring of the medical isolation and quarantine settings.
27 Several principles must be applied to medical isolation and quarantine
28 settings in order to achieve this goal, however. First, a housing area or unit
being utilized for medical isolation and quarantine cannot simultaneously be
used for solitary confinement, whether termed punishment, punitive or

¹⁵ https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf

1 administrative segregation. Any mixing of these very different sets of
2 priorities and tasks will result in the medical isolation patients and
3 quarantined individuals being treated in a punitive manner. In addition, this
4 approach creates many very difficult infection control issues for the people
detained in these units and the staff who work in them.

5 36. A second principle that must be applied to medical isolation is that every
6 person should have a clinical encounter outside of their cell at least once a
7 day. This encounter should include physical examination in a room designed
8 for clinical care with an examination table, sink, no-touch waste receptacle
9 and computer terminal for systems using electronic medical records. These
10 encounters should have a standard set of elements for each encounter,
11 including what symptoms will be asked about, what objective signs will be
12 measured, and a protocol for nursing staff who conduct these assessments on
13 when these encounters should elicit a higher level assessment by a
physician. Anyone placed into medical isolation should be evaluated by a
physician or mid-level provider within 2 hours, and subsequently at least
once every four days unless daily nursing encounters reveal new or
worsening symptoms of COVID-19 or abnormal vital signs.

14 37. A third principle for medical isolation and quarantine is that patients must be
15 afforded recreation, phone calls, access to tablets and reading material just as
16 they were before. In order to implement these measures, ICE must dedicate
17 resources, both clinical and security staffing. My experiences with medical
18 isolation in a non-punitive manner is that for every five patients in a medical
isolation unit, there is a need for one additional nurse and one additional
security officer to ensure their care.

19 38. The use of solitary confinement as medical isolation or quarantine, or any
20 practice that results in placement of a person into a locked cell for 22 or
21 more hours per day, is likely to increase the risk of serious illness or death
22 from COVID-19. Once people are placed into locked cells, the default
23 becomes that they remain in those cells unless security and health staff take
24 steps to ensure their removal for medical care, recreation and other activities.
25 During an outbreak, staff may become reluctant to do so, or they may simply
26 be unable to keep up with a schedule of out of cell time as the number of
27 people in this type of custody increases. If solitary confinement is utilized as
28 a primary response to COVID-19, the natural tendency to avoid out of cell
time can quickly result in decompensation of patients locked in their cells,
with little or no awareness of staff. This type of decompensation increases
the risk of hospitalization and serious complications from COVID-19. These
dangers are compounded by the fact that people can deteriorate rapidly and
unexpectedly from COVID-19.

- 1
- 2 39. In addition, general lockdown, or confinement to cells 22 or more hours a
- 3 day, for the general population for purposes of quarantining is likewise an
- 4 inappropriate and dangerous response to COVID-19. Such an approach is
- 5 dangerous and misguided. First, prolonged isolation causes severe
- 6 psychiatric stress, and has been known to cause suicidality and mental
- 7 decompensation. Moreover, in my experience, people forced into isolation
- 8 quickly become resistant to this practice because of the severe psychological
- 9 stress that it creates, and the result is an increase in the likelihood of use of
- 10 force and other security problems that can actually increase physical contact
- 11 between security staff and detainees, thereby increasing likelihood of
- 12 transmission.
- 13
- 14 40. Finally, solitary confinement is not a prudent infection control measure. The
- 15 primary vector for introduction of COVID-19 is staff, not detainees. Staff
- 16 not only come and go from the facility many more times per day than
- 17 detainees, they also move throughout every part of the facility, unlike
- 18 detainees who are generally restricted to a small area. This approach of cell
- 19 isolation is tantamount to imposing punishment on detainees in the guise of
- 20 infection control. A preferable approach is to allow for significantly more
- 21 time out of cells, but to stagger these times, implement social distancing, and
- 22 use of PPE, all of which requires an adequate commitment of staff.
- 23
- 24 41. Defendants could remedy many of these defects simply by providing clear
- 25 guidance and mandates to facilities in their PRR. For example, the PRR
- 26 acknowledges the need for isolation beds and even notes that transfer,
- 27 hospitalization, or release may be necessary where a facility does not have
- 28 sufficient isolation beds. The revised PRR, however, fails to provide
- facilities with adequate guidance as to what isolation appropriately means. The PRR should make clear that medical isolation and quarantines should not be solitary confinement conditions. And to the extent proper medical isolation beds are not available in a facility, then the PRR should further clarify that release/hospitalization is necessary—and that finding beds in conditions equivalent to solitary confinement is not proper. The revised PRR's failure to include such guidance and safeguards means that medically vulnerable people remain at significant risk of being inappropriately placed into solitary confinement conditions that threaten their physical and mental health.

ICE's Definition of Severe Psychiatric Illness

42. The ICE directive regarding which detainees should be considered for

1 release based on the presence of “Severe Psychiatric Illness” is
2 inappropriate. Traditional definitions of serious mental illness in detention
3 settings include many more psychiatric diagnoses, including major
4 depression and personality disorders that are well known to be associated
5 with impairments of insight and judgement.¹⁶ There are several key
6 omissions and errors in the approach taken by ICE.

7 43. First, the list utilized by ICE omits many of the major psychiatric diagnoses
8 that would impair the ability to engage in COVID-19 prevention, diagnosis
9 and treatment efforts. ICE has listed several diagnoses associated with
10 psychosis and intellectual or neurocognitive deficits, but has omitted
11 significant diagnoses including major depressive disorder. In addition, there
12 are numerous other diagnoses that may result in profound functional
13 impairments that render patients unable to appreciate or engage with health
14 services and COVID-19 prevention, diagnosis and treatment efforts,
15 including but not limited to post-traumatic stress disorder and anxiety
16 disorders. The primary reason that these diagnoses should be added, along
17 with any person who is experiencing functional impairments that impede
18 insight or judgment, is that people with serious mental illness may face
19 challenges in identifying or reporting symptoms of COVID-19. These
20 challenges may not be clearly identifiable by staff, and it is very possible
21 that people with severe depression, anxiety, PTSD and other psychiatric
22 problems may simply avoid health staff. As a result, it is important to
23 affirmatively include them as part of the high-risk cohort and implement
24 active surveillance for COVID-19, meaning that twice per day, they should
25 be assessed by a health professional for symptoms of COVID-19 along with
26 signs of mental health deterioration.

27 44. Second, there are people who are prescribed psychotropic medications that
28 render them heat sensitive, meaning that the medication they take impairs
the ability of their body to regulate heat. This issue is relevant in high heat
settings, but it is also relevant to COVID-19, because of the role of fever and
dehydration in both conditions. Many of the chronic health problems that
already qualify as COVID-19 risk factors, including heart and lung disease,
and diabetes, are markers of heat sensitivity. As a result, any person who is
heat sensitive because of medications or because of a health problem should
be considered as high-risk for serious illness or death from COVID-19.¹⁷

¹⁶ <https://www.mass.gov/files/documents/2016/09/ov/622.pdf> and
<https://www.gao.gov/assets/700/690090.pdf>

¹⁷ https://dbh.dc.gov/sites/default/files/dc/sites/dmh/release_content/attachments/877

- 1
- 2 45. Third, identification of people who meet these criteria should also result in
- 3 increased surveillance and engagement while detained. This includes at least
- 4 daily (but preferably at least twice daily) monitoring of signs and symptoms
- 5 of COVID-19 by health staff, implementation of social distancing in housing
- 6 areas and common spaces, including pill lines, and access to hand washing
- 7 and hand sanitizer. People who have serious mental illness should also be
- 8 considered for cohorting into specialized housing areas, where they can
- 9 receive group and individual therapy and other activities designed to reduce
- 10 or mitigate the risks of harm conferred by detention. If people with severe
- 11 mental illness become infected and are placed in medical isolation, then they
- 12 should be provided regular screenings by mental health staff to ensure they
- 13 are not deteriorating.
- 14 46. The revised PRR altogether fail to include these necessary precautions, thus
- 15 heightening the risk of harm to people with severe psychiatric illnesses.

16 **Need for Care of COVID-19 Patients**

- 17 47. It is imperative that ICE create a COVID-19 plan for the care of anyone who
- 18 is at increased risk of serious illness or death from COVID-19. As it stands,
- 19 the PRR lacks such a plan. Such a plan would involve, at a minimum,
- 20 reviewing a patient's high-risk status, assessing the degree to which their
- 21 health problems are under control, and evaluating the impact of their
- 22 medications for their conditions on COVID (e.g., some essential medications
- 23 impact the body's immune response or may otherwise create special
- 24 vulnerabilities during COVID-19 infection). That level-of-control
- 25 assessment would detail the patient's baseline symptoms, including the
- 26 frequency of symptoms and circumstances under which the symptoms
- 27 improve or worsen and the efficacy of any current medication. A care plan
- 28 for an individual at a high-risk for COVID-19 would also provide enhanced
- education about COVID-19 symptoms and planning tailored to the
- possibility of COVID-19 infection, which would generally involve daily
- screening for COVID-19 symptoms. This approach is especially critical for
- detainees with any heart or lung problems, or other conditions that include
- symptoms that can appear very similar to those for COVID-19. These
- measures are not mere best practices — they are all standard elements of
- care planning that I have implemented time and time again to protect high-

[7/heatadvice.pdf](https://www.health.harvard.edu/skin-and-hair/10-types-of-medications) and <https://www.health.harvard.edu/skin-and-hair/10-types-of-medications> and <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4921a3.htm>

1 risk patients during outbreaks in prisons and jails. They are necessary
2 components of care-planning for patients at a high risk of COVID-19
3 infection, because the CDC explicitly states that poorly controlled health
4 problems represent additional risk for people infected by COVID-19, over
and above the risk created simply by having a particular health problem.

5 48. Care for COVID-19 patients extends beyond simply clearing them to return
6 to general population housing areas because they have reached a 14-day
7 mark after their diagnosis. The World Health Organization has reported that
8 physical recovery from COVID-19 can extend well beyond the period of
9 active infection, taking six weeks or longer.¹⁸ Many of the people I have
10 spoken with in detention settings report ongoing symptoms post-COVID-19
11 infection including shortness of breath, chest pain, tinnitus and daily
12 headaches. These symptoms last weeks or longer and ICE must create a plan
of care that assesses, documents and treats these problems among detained
people. At times, patients may appear to be improving and their condition
may worsen unexpectedly and rapidly; ICE's PRR must contemplate these
foreseeable circumstances.

13 49. Once a person leaves medical isolation, they should be transferred into a
14 housing area for people recovering from COVID-19. Here, detainees should
15 continue to be exempt from work requirements and every person in these
16 units should have a clinical encounter for every person who is known or
17 suspected to have experienced COVID-19 with a physician to assess any
18 new symptoms or disabilities that exist and create a plan for recovery that
19 addresses their symptoms and disability. For example, Mr. Aguirre reports in
20 his declaration that weeks after being diagnosed with COVID-19, he is
21 experiencing shortness of breath, but he has not been evaluated by a
22 physician for this ongoing issue. Aguirre Decl. ¶13. This is especially
dangerous given that COVID-19 can cause serious complications to a
person's health that last after infection. These units must also be adequately
staffed by qualified medical personnel who are qualified to take patients'
vitals and check symptoms.

23 50. Basic elements of a post COVID-19 assessment include asking patients
24 whether they experienced any of the CDC listed symptoms during their
25 COVID-19 infection, and whether they continue to experience any of those,
26 or any other symptoms. This COVID-19 recovery encounter should occur
27 with every patient who was confirmed or is suspected of having COVID-19.
These efforts will likely include pulmonary rehabilitation and physical

28 ¹⁸ <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>

1 therapy or exercise as part of what patients need to recover from COVID-
2 19.¹⁹ At a baseline, any patient who experienced shortness of breath or other
3 pulmonary symptoms should have their respiratory status and symptoms
4 documented and be considered for incentive spirometry.²⁰ Patients with
5 chest pain should be evaluated for cardiac complications of COVID-19, have
6 an EKG conducted and referred for cardiology consultation. Because
7 COVID-19 is associated with high rates of blood clots as well as kidney and
8 liver damage, these recovery encounters should also contain structured
9 questions to elicit, and when indicated, conduct laboratory testing for these
10 concerns.

11 51. Implementing these basic and required elements of COVID-19 care will
12 require adequate staff as well as training. Many of the declarations I have
13 reviewed indicate that even basic health encounters that occur presently do
14 not result in competent documentation of findings or communication with
15 patients. Mr. Aguirre reported that even when he was ill with COVID-19,
16 health staff who took his vital signs would not always write them down into
17 his records. Aguirre Decl. ¶¶ 5, 9. He also reported that he was not given his
18 COVID-19 test results in writing by health staff. *Id.* ¶ 10.

19 52. Unfortunately, ICE's revised PRR fails to prescribe any of these medically
20 necessary protocols for the care and treatment of COVID-19 patients,
21 particularly those who are medically vulnerable. In my expert opinion, it is
22 crucial that ICE specifically prescribe such precautionary measures to
23 protect medically vulnerable from infection, during their illness, and as they
24 are recovering.

25 ICE's Oversight of COVID-19 is Deficient

26 53. The ICE checklists I have reviewed reveal multiple deficiencies in how ICE
27 is overseeing facilities' COVID-19 response generally and protecting
28 medically vulnerable people specifically.

54. Checklists can be important features of ensuring adequate provision of
health and other services, but when utilized to measure tasks that are not
well-suited to a simple checkoff process, there is ample research to show
that they can be ineffective and even counterproductive.²¹ In order to

¹⁹ https://rehabmed.weill.cornell.edu/sites/default/files/post_covid_rehab_patient_guide_0.pdf and <https://www.healthline.com/health-news/what-to-do-after-recovering-from-covid-19#Walking>

²⁰ <https://lunginstitute.com/blog/incentive-spirometry-benefits/>

²¹ <https://psnet.ahrq.gov/primer/checklists>

1 actually improve the outcomes of an important process, a checklist must
2 measure tasks or outcomes that are amenable to a yes or no measurement,
3 and the use of a checklist must be monitored to ensure that the elements
4 being recorded actually reflect the truth. Without these elements, a checklist
5 quickly becomes a rote administrative exercise, divorced from the realities
6 of whatever process was originally being monitored.

7 55. I have reviewed checklist surveys from approximately 132 facilities, of
8 which approximately 97 use the same questionnaire. These checklists
9 contain many errors in scope and content.

10 56. For example, the checklists or surveys utilized by ICE fail to address the
11 identification and care of high-risk detainees. As mentioned above, every
12 high-risk patient should have an encounter with a physician or mid-level
13 provider to assess their specific risks for COVID-19 and create a plan of
14 care. Since the high-risk detainees have largely been identified, a checklist
15 could be utilized to ensure that every person in this cohort has received this
16 type of encounter. More generally, the checklists or survey should have
17 several questions about what special protections are being implemented for
18 high-risk detainees.

19 57. In addition, many of the processes included in the ICE checklists require
20 ongoing monitoring, not a checklist question. For example, social distancing
21 and infection control are complex areas of work that require development
22 and implementation of quality assurance tools to ensure that these policies
23 are followed. The presence of a policy may be worth noting in a checklist,
24 but the standard in infection control and detention management is to have
25 monthly monitoring of how and whether that policy is implemented. The
26 checklists also often do not address the adequacy or underlying elements of
27 an adequate policy—only the existence of a policy. In any event, many of
28 the declarations I have reviewed indicate that facility policies are not being
followed. For example, Mr. Aguirre reported in his declaration that multiple
people would use the same phone in the new admission area without any
cleaning or disinfecting in between uses. Aguirre Decl. ¶4.

58. The lack of any meaningful monitoring of implementation is reflected
throughout the checklist and thus, the mention of these critical areas of work
in the checklists is not likely to make a meaningful contribution to the health
of detainees. Critical areas that require quality assurance assessments with
monthly monitoring and central review include screening of detainees and
staff (daily screening for symptoms and signs of COVID-19), the training of
staff for, and implementation of, contact tracing, the clinical care of people

1 in medical isolation and in recovery for COVID-19, amongst other issues.
2 Meaningful assessments of these benchmarks are lacking from the
3 checklists.

4 59. Related to the lack of quality assurance in this approach by ICE, there does
5 not appear to be any clear method to how these checklists will be reviewed,
6 or how reviews would result in any action that finds or addresses
7 deficiencies. Many of the checklists or surveys that I reviewed included
8 deficiencies but no plan for how those deficiencies would be addressed.
9 Rather, they are simply reports by facility staff, such as wardens and facility
10 administrators, who already have a bias not to report deficiencies. Although
11 I understand that Detention Service Managers (“DSMs”) and Detention
12 Standards Compliance Officers (“DSCOs”) are charged with reviewing and
13 following up on these checklists, it is unlikely that they have the medical
14 training necessary to perform these tasks, such as an assessment of the
15 adequacy of any policies concerning medical care or audits of medical
16 staffing ratios. DSMs and DSCOs also do not have adequate training for
17 oversight checklists. Further, as discussed below, I have reviewed several
18 survey responses that indicate the need for follow-up, but there is no
19 indication that that follow-up was actually conducted.

20 60. For example:

- 21 • The survey response for Chase County Detention Facility (beginning at
22 ICE00001512) indicates that the facility is not adequately supplied with
23 cleaning products to maintain a sterile work environment for 30 days, that
24 the facility does not have disinfecting or sanitizing protocols for
25 transportation assets, that the facility does not have staff training plans, and
26 that there are no policies or procedures in place to disinfect detainee funds
27 and personal property;
- 28 • The survey response for the Adams County Detention Center (beginning at
ICE1264) states that detainees have not received training on how to correctly
don PPE, and that over 100 detained individuals were transferred to the
facility in mid-May;
- The survey response for the Glades County facility (beginning at ICE975)
indicates that detainees are not wearing a mask during the custody
classification process, that alternate work arrangements have not been
implemented, and that transfers of detainees have not been appropriately
restricted.
- It also appears that many facilities leave checklist or survey responses blank
or with generic responses. Many of the responses by ICE vendor GEO
include nonspecific responses such as “GEO is following applicable

1 sanitation policies, standards, CDC, and ICE guidance to determine the
2 facility's sanitation schedule." This type of response is present for multiple
3 areas of questions and reflects a lack of training or oversight in this process.

- 4 61. In addition, it appears that some facilities have not responded to these
5 surveys at all.

6 **June 22 Revisions to PRR**

- 7 62. I have reviewed ICE's recent revisions to the PRR. As I note in various
8 sections above, ICE's revisions are minimal, inadequate, and fail to address
9 and mandate crucially needed precautions. As a result, the PRR continues to
10 fail to ensure that people with Risk Factors are protected from COVID-19.

- 11 63. As an initial matter, the PRR revisions fail to meaningfully address and
12 remediate the deficiencies outlined above concerning ongoing transfers,
13 inadequate testing, overuse of solitary confinement, improper use of harsh
14 disinfectants, and lack of increased medical surveillance and care planning
15 for people with Risk Factors. The PRR likewise continues to fail to prescribe
16 necessary medical staffing ratios and does not provide meaningful clinical
17 guidance regarding the treatment and monitoring of COVID-19 generally or
18 people with Risk Factors specifically. In fact, although the PRR discusses
19 precautionary measures in general terms, the PRR is almost altogether
20 lacking in terms of providing specific guidance on how to actually treat
21 COVID-19 and what increased treatment and monitoring precautions are
22 crucial for people with Risk Factors. In fact, aside from outlining the
23 custody redetermination process for people with Risk Factors, the PRR
24 revisions add almost no precautions specifically aimed at creating safer
25 detention conditions for people with Risk Factors. This is dangerous. A
26 proper set of guidelines to facilities would outline not only how to prevent
27 the spread of COVID-19 but also prescribe protocols for pre-infection
28 planning of medically vulnerable people, treatment of medically vulnerable
people, enhanced surveillance, and post-recovery evaluations and
assessments.

- 24 64. Even in those instances where the PRR revisions add some precautions,
25 those precautions remain deficient. For example, the PRR requires that
26 detention facility staff wear PPE when they are within 6 feet of detained
27 people. However, the PRR does not mandate that staff wear PPE when they
28 are in close proximity to facility staff or other visitors—notwithstanding the
fact that staff and visitors are more likely to infect people.

65. As another example, the revised PRR fails to mandate that newly admitted

1 detainees be cohorted for 14 days, which is a correctional standard and
2 recommendation of the CDC. To simply indicate that facilities should utilize
3 “considerable effort” to achieve such a basic infection control standard
4 indicates that ICE is not ready to measure or hold accountable its facilities.

5 ***

6 66. I have knowledge of the following information relating to the conditions
7 facing migrants in immigration detention centers, and I can testify to it if
8 needed.

9 I declare under penalty of perjury and under the laws of the United States, pursuant
10 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
11 knowledge, memory, and belief.

12 Executed on the 24th of June, in the year 2020, in the city of Port Washington, NY.

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18 Dr. Homer Venters
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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.
U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF JESSICA
SCHNEIDER**

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27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF JESSICA SCHNEIDER

I, Jessica Schneider, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Jessica Schneider. I am an attorney who is barred in the state of Florida and have been practicing immigration law for over ten years. I serve as the Director of the Detention Program at Americans for Immigrant Justice (“AI Justice”). AI Justice is a non-profit organization which seeks to protect and promote the basic human rights of immigrants through a unique combination of free direct services, impact litigation, policy reform, and public education at local, state, and national levels. The Detention Program provides free legal representation and legal education to detained individuals through Know Your Rights presentations and direct representation of individuals in removal proceedings. The Detention Program regularly monitors conditions in detention facilities to bring about systemic change.
2. AI Justice works with individuals who are detained at the Krome Service Processing Center (“Krome”) in Miami, Florida, the Broward Transitional Center (“BTC”) in Pompano Beach, Florida, and the Glades County Detention Center (“Glades”) in Moore Haven, Florida.
3. Since the outbreak of the COVID-19 pandemic, seven staff persons have been in continuous contact with detained individuals at the three facilities we serve and have reported their findings to me. At Krome, we communicate with clients and other detained individuals through the mail and phone calls using the pro bono telephone line assigned to our organization. At BTC, we can communicate with clients and other detained individuals through Skype video calls, as well as the mail and phone calls through the pro bono line. Lastly, at Glades, we communicate with clients through phone calls and the “Getting Out” communication platform.
4. I am familiar with the *Fraiha* subclasses pursuant to the April 20, 2020 order.

Custody Redetermination Requests

5. Based on AI Justice's knowledge and understanding, ICE is not conducting individualized custody determination requests pursuant to the April 20, 2020 order.
6. As of June 23, 2020, our staff has filed custody redetermination requests for approximately eighteen individuals detained at BTC, Krome, and Glades. To date, we have seen only one Fraihat subclass members released, but it was upon the condition of paying a \$12,000 bond.
7. Although the three facilities fall under the Miami Field Office, locating the appropriate Deportation Officer ("DO") to submit the release request has presented a significant challenge. Not all individuals detained in the three facilities are assigned to DOs under the Miami Field Office. Rather, they are detained in the Florida facilities under a "room and board" policy but continue to be docketed with a DO in another facility. For example, we have seen individuals transferred from ICE facilities in Arizona, Texas, Louisiana, and Georgia who, despite being physically present in the Miami Area of Responsibility, continue to be docketed with the DOs at the facility from which they were transferred. Trying to locate proper DOs in other states, facilities, and areas of responsibility presents a significant barrier and unnecessary delay in submitting urgent release requests on behalf of our clients.
8. Of the eighteen requests our office has submitted, one was granted upon the payment of a \$12,000 bond, ten were denied, and the other seven are still pending. In most cases, we have received no justification or analysis for the denials. Upon further inquiry, we receive boilerplate responses that do not include an analysis or mention of the client's health condition or risk to COVID-19.
9. AI Justice submitted a release request for a Fraihat subclass member with severe asthma. Our client's asthma is so severe that you can hear him struggling to breathe through the phone during conversations. The client requires two inhalers, a nightly anti-allergy pill, and a nose spray. He also requires a monthly or bi-monthly steroid treatment to treat his asthma. When

1 the client was initially transferred from Pine Prairie Detention to BTC, BTC
2 refused to give the client his steroid treatment, which led to a multiple-day
3 asthma attack during which the client could not get out of bed. The client has
4 had to use his emergency inhaler so frequently that he has finished it in a
week.

5 10. On April 17, 2020, our office submitted a formal release request to the BTC
6 Deportation Officer. At this point, the Deportation Officer replied that the
7 client was "room and board" only at BTC. On April 28, 2020, our office re-
8 submitted the release request to the Deportation Officer in Oakdale,
9 Louisiana. The Oakdale ICE office mailed the denial directly to the client on
10 April 29, 2020, a mere 24 hours after the release request had been submitted.
11 Our office requested a copy of the denial from the Oakdale ICE office
12 multiple times and did not receive one. Our office re-submitted a release
13 request on May 4, 2020, citing the *Frailhat* case. On May 13, 2020, the
14 Oakdale Deportation Officer told us they issued a denial on April 29, 2020,
15 once again without sending a copy of the denial. We request a re-
16 consideration given it was re-submitted under *Frailhat*. On May 18, 2020,
17 the Oakdale ICE office emailed us stating that on May 1, 2020, they
18 reconsidered and decided to continue detention. Again, no formal paperwork
19 of the denial was mailed to the attorney after multiple requests. The client
20 was able to make a copy of the paperwork he was sent in English and mail it
21 to us. The denial stated he would not be released because he has a removal
22 order, and the Cuban government has agreed to accept him. There was no
23 analysis of a release based on his health condition.

24 11. At the end of April 2020, AI Justice submitted a release request on behalf of
25 a Cuban client with an order of removal who suffers from asthma. He
26 manages asthma using an inhaler. The client had a U.S. citizen sponsor
27 located in Miami, Florida, and does not have a criminal history. Less than
28 two days later, ICE denied the release request stating that the client at the
time was mandatory detention pursuant to 8 U.S.C. § 1231(a)(1) and that his
removal was imminent. He was later transferred to the Stewart Detention
Center in mid-May, 2020. Despite claims that his removal was imminent,
the client has yet to be deported, and he continues to be detained. Although
the client is no longer mandatory detention as he is out of the initial 90 day
removal period, he remains in detention.

12. On May 20, 2020, our office filed a custody redetermination request for a
client at Krome, who is HIV positive. ERO Miami denied the request. In the
initial email notification regarding the denial, ICE did not provide any

1 reasoning. Once we followed up requesting a reason for the denial a reason,
2 ICE stated that “[t]he reasons for why we are denying the release request due
3 to mandatory detention [sic], potential threat to public safety and flight risk,
4 this is all taken in consideration when a release is requested and also his
5 crimes.” The client is a green card holder, has lived in the United States
6 since 2001, and has seven U.S. Citizen children and a U.S. Citizen partner,
7 with whom he has been with since 2004. There was no indication that ICE
8 had considered the client’s health condition when making its custody
9 determination.

10 **Conditions of Detention**

11 13. As of June 23, 2020, our staff have confirmed that people with risk factors
12 at BTC, Krome, and Glades are not being provided with sufficient room to
13 practice social distancing. Detained individuals have described
14 circumstances in which they can reach out and touch the person next to them
15 while lying in bed. They are further forced to eat at communal tables in
16 which they are unable to practice social distancing. Many detained
17 individuals have shared with us that maintaining social distancing is
18 “impossible.”

19 14. Clients and other detained individuals have reported that they still do not
20 have access to sufficient soap, hand sanitizer, or cleaning supplies to wash
21 themselves and their living areas. Individuals have further reported that
22 when they request additional soap, they are often denied and are forced to go
23 without soap for a while.

24 15. We have heard that staff and detainees are still not wearing surgical masks
25 consistently. Detained individuals at Krome and Glades are given masks
26 once a week. Individuals detained at BTC are given masks three times a
27 week. However, neither the individuals detained nor the guards use the
28 masks consistently. We are told guards pull their masks down their chin
because they are bothersome.

16. We have heard that detained individuals are not wearing gloves. Detained
individuals have asked for gloves and have not received them. At BTC,

1 detainees are not given gloves unless they are cleaning common areas or
2 working in the kitchen. We have heard that some staff wear gloves.
3 However, staff wear the same gloves for hours at a time and touch multiple
4 surfaces during this time. These harmful practices of touch and go results in
5 cross-contamination. For gloves to be effective, they must be changed
6 between each activity to avoid cross-contamination. People detained in BTC
7 have shared with us that they often see guards not wearing gloves or not
8 changing gloves frequently. For example, guards will wear the same pair of
9 gloves when doing random room searches, touching everyone's personal
10 belongings with the same pair of gloves.

11 17. AI Justice is aware of dozens of people who are still being detained at
12 Glades, Krome, and BTC who are elderly or immunocompromised due to
13 diabetes, high blood pressure, and other underlying medical conditions that
14 put them at high risk of contracting and suffering deadly consequences from
15 COVID-19. Glades, Krome, and BTC have not released these individuals
16 despite ICE directives to release medically vulnerable people and the
17 elderly. We are aware of people detained at BTC with asthma, diabetes, and
18 high blood pressure who are receiving medical care in detention. ICE is
19 aware of these cases, given that the medical file is part of the person's file,
20 and have not made any efforts to review cases and make releases.

21 18. AI Justice knows individuals detained at Broward Transitional Center,
22 Krome Service Processing Center, and Glades County Detention Center,
23 who are exhibiting symptoms of COVID-19 and have tested positive for the
24 virus. As of June 2, 2020, detained individuals from Glades County
25 Detention Center report being sick or witnessing other people with coughs,
26 chills, fevers, and other symptoms and report that they were receiving
27 minimal to no medical treatment. We have also heard reports that sick
28 individuals at Glades have lost consciousness and were carried out of their
housing unit in a wheelchair because they were so weak and unwell.

19. I, along with the other members at AI Justice, are extremely concerned by
ICE's response to the pandemic. We fear for the safety and well-being of the
detained individuals at the facilities we serve. We continue to be deeply
frustrated and horrified by the lack of efforts ICE and its contractors have
made to release vulnerable people and ensure safe conditions for those that

1 remain in their custody. We fear that its actions are putting hundreds of
2 individuals at serious risk of harm or death.

3 I declare under penalty of perjury and under the laws of the United States, pursuant
4 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
5 knowledge, memory, and belief.

6 Executed on June 23, in the year 2020, in the city of Miami, Florida.

7 /s/ Jessica Schneider

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9 Jessica Schneider, Esq.
10 Americans for Immigrant Justice
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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.

U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF JESSICA
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*Admitted Pro Hac Vice

**Pro Hac Vice Application Forthcoming

DECLARATION OF JESSICA MYERS VOSBURGH

I, Jessica Myers Vosburgh, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Jessica Myers Vosburgh. I serve as the Executive and Legal Director of Adelante Alabama Worker Center (“Adelante”). Adelante is a non-profit community organization in Birmingham, Alabama dedicated to uniting low-wage and immigrant workers and their families to defend their rights, promote their dignity, and pursue justice for all. In my capacity as an attorney at Adelante, I represent individuals seeking release from prolonged detention in Alabama; I also occasionally represent members of the Birmingham community in bond and removal proceedings. Adelante is also a member of the Shut Down Etowah campaign, aimed at exposing human rights abuses at the infamous Etowah County Detention Center.
2. The primary detention center that Adelante serves is the Etowah County Detention Center (“Etowah”), located in Gadsden, Alabama. Etowah is under the jurisdiction of the ICE ERO New Orleans Field Office.
3. Since the outbreak of the COVID-19 pandemic, I have been in contact with dozens of individuals detained in Etowah. I have met with detainees in-person and over the phone, and some of my existing clients who are detained in Etowah relayed additional information to me about fellow detainees.
4. I am familiar with the Fraihat subclasses pursuant to the April 20, 2020 order.

Custody Redetermination Requests

5. Based on my knowledge and understanding, ICE is not conducting meaningful individualized custody determination requests pursuant to the April 20, 2020 order.
6. I represented, along with co-counsel, eighteen individuals detained in Etowah who are at heightened risk for serious complications or death from

COVID-19 based on their age and/or underlying chronic medical conditions. *See Archilla v. Witte*, 4:20-cv-00596-RDP-JHE (N.D. Ala. April 29, 2020). One of the plaintiffs, Alex Hernandez, is also one of the class representatives in the *Fraihat* litigation. We submitted extensive evidence to the court in that case, including declarations from the plaintiffs and medical and public health experts, documenting plaintiffs’ medical conditions, their heightened risk for COVID-19, and ICE and Etowah County officials’ failure to implement adequate measures to protect the plaintiffs’ basic safety and health.

7. On May 15, 2020, the Court denied our motion for a temporary restraining order seeking plaintiffs’ immediate release in *Archilla*. *See id.*, ECF No. 34 (Memorandum Opinion). Although the Court primarily denied the motion based on the conclusion that it lacked jurisdiction to order plaintiffs’ release, it also discussed the *Fraihat* case at length, *see id.* 8-10, 38-39, crediting the claims of ICE officials in Etowah that they were complying with the preliminary injunction, and reasoning that *Fraihat* provides plaintiffs “a clear avenue to secure the relief they seek”—namely, release. *Id.* at 39. Plaintiffs recently filed a notice of voluntary dismissal in *Archilla*.
8. In filings in the Court in the *Archilla* case, a supervisory ICE official in Etowah acknowledged that sixteen of the eighteen plaintiffs were *Fraihat* class members. ICE does not recognize the remaining two plaintiffs as class members, despite allegations and evidence presented to the Court that one suffers from hypertension and a heart murmur, and the other suffers from hypertension and a seizure disorder. According to ICE, these two individuals have not received individualized custody reviews pursuant the *Fraihat* injunction.
9. ICE claims to have conducted individualized custody reviews for the other sixteen plaintiffs. Not a single one has been released. Nor have they been provided with any notice of a review, opportunity to present evidence or notice of ICE’s decision. These appear to be cursory reviews in name only. According to government counsel in *Archilla*, for all individuals detained in Etowah who are identified by ICE as *Fraihat* class members, ICE “reviewed all of the relevant available information, including medical records, the A file, documents provided by the alien, and appropriate ICE databases, to

determine whether continued detention was appropriate in light of the COVID-19 pandemic.” Individuals were not provided with notice of ICE’s custody decision unless they submitted a parole request.

10. One of the plaintiffs in *Archilla* submitted a pro se *Fraihat* custody review request to his deportation officer and the field office on June 1. As of June 16, 2020, he has not received any acknowledgment or decision regarding his request.

11. I am aware of other individuals detained in Etowah who have submitted *Fraihat* custody review requests and received prompt summary denials with no explanation of the basis for the decision.

Conditions of Detention

12. ICE and county officials in Etowah are failing on multiple fronts to protect detained individuals from the grave risks posed by COVID-19.

13. Through communications with the plaintiffs in *Archilla*, my other individual habeas clients, and other detained individuals in Etowah, I have learned that the facility continues to engage in dangerous practices such as crowding detainees into a single unit, denying access to adequate PPE, cleaning, and personal hygiene supplies, continuing to transfer individuals in and out of the jail (including at least one COVID-positive detainee) and failing to abide by ICE and the facility’s own quarantine/isolation procedures.

14. Early on in the pandemic, ICE consolidated over one hundred immigrant detainees into a single unit – Unit 9 – within the jail. That unit is now at or above capacity.

15. Detainees in Unit 9 are not able to implement social distancing. Over one hundred detainees share only a few showers, phones, kiosks, microwaves, and other common areas. Most detainees are housed in two- or four-person cells. Detainees sleep only a few feet away from each other, and the combined sink and lidless toilet inside the cell. In recent weeks, detainees have been kept on lockdown for 22 to 23 hours per day. Several detainees recently reported that the plumbing in their cell was broken, making it

1 impossible to wash their hands or use the toilet during these extensive
2 lockdown hours.

3 16. ICE detainees in Etowah are not provided with adequate personal protective
4 equipment or cleaning and hygiene supplies. In mid- to late April, detainees
5 were provided with a single mask. They were required to wear the same
6 mask for two or three weeks at a time, even if it became soiled. Although
7 detainees are expected to clean their own cells and all the common areas
8 within the unit, they are not provided enough cleaning supplies and
disinfectants.

9 17. ICE continues to transfer individuals in and out of the jail on a regular basis.
10 On or around April 21, 2020, ICE transferred a confirmed COVID-positive
11 individual into Etowah. According to publicly available data, it appears that
12 ICE has transferred from one to ten individuals into Etowah each week since
13 mid-March. In the last two weeks alone, over thirty new immigrant detainees
have been booked into Etowah.

14 18. These transfer numbers do not include the hundreds of pre-trial county jail
15 inmates who have been booked into the jail since the start of the pandemic.
16 Although ICE detainees and county inmates are housed in separate units
17 within Etowah, jail staff and contractors regularly move among units, and
18 county inmates with job responsibilities such as cleaning, meal delivery, and
19 commissary regularly enter into the ICE unit. And all new admittees to the
20 jail—both ICE and county—are brought in through the same intake area,
21 where they are placed in group holding cells or seated on benches in an open
area, within only a few feet of other detainees, inmates, and jail staff.

22 19. One of the individuals recently transferred to Etowah is G.M., who I
23 represent on a habeas petition. He was previously detained at Etowah and
24 then transferred in mid-March to LaSalle ICE Processing Center in Jena,
25 Louisiana—a facility that has multiple documented cases of COVID-19
26 among detainees and staff. While there, he was housed in a dorm-style unit
27 with over 50 individuals, several of which presented COVID-19 symptoms
28 but were not tested. He was transferred back to Etowah last week. He is back
in Unit 9.

1 20. Another one of my habeas clients, A.A., a *Frailhat* class member, has been
2 brought out of Etowah to the local hospital twice in the past two months.
3 When readmitting him to the jail, ICE and county officials have failed to
4 follow their own isolation procedures, despite Mr. A.'s heightened
5 vulnerability and his possible exposure to COVID-19 during the hospital
6 visits. Mr. A. is pre-diabetic and suffers from hypertension, high cholesterol,
7 and stomach/gallbladder issues, for which he takes multiple medications. He
8 also suffers from psychological issues likely stemming from his persecution
9 and torture in his country of origin, and his father's murder.

10 21. In early May, Mr. A. was rushed to the hospital after experiencing shortness
11 of breath, chest pain, diarrhea, and stomach pain. His blood pressure was
12 extremely elevated. While in the emergency department, he was placed on a
13 stretcher within six feet of other sick individuals, some of whom were
14 coughing. He was never administered a COVID-19 test, either at the hospital
15 or upon being readmitted to the jail. He was brought back in through the
16 common intake area and then placed in an "isolation" cell in a separate unit.
17 Although ICE claims that all new individuals admitted to the jail are isolated
18 for 14 days before being placed in a housing unit, Mr. A. was only in
19 isolation for approximately seven days before being returned to Unit 9.
20 During that time, he was locked in an individual cell that was extremely
21 dirty; he was required to clean it himself. He was given his same unwashed
22 bed linens from before he was brought out to the hospital. He had no access
23 to a shower and had to bathe himself with a towel in the sink. He only had
24 his vitals checked twice. He was refused his request to speak to me while in
25 isolation.

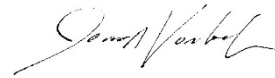
26 22. In mid-June, Mr. A. was again brought out to the hospital where he came
27 into close contact with visibly sick patients. He then was transferred directly
28 back into the unit the same day without undergoing any process of
quarantine/isolation.

29 23. I, along with other staff and members of Adelante and community members
in Gadsden, Birmingham, and across Alabama, am extremely concerned by
ICE's response to the pandemic. We fear for the safety and well-being of the
detained individuals at the facilities we serve. We continue to be deeply
frustrated and horrified by the lack of efforts ICE and its contractors have

1 made to release vulnerable people and ensure safe conditions for those that
2 remain in their custody. We fear that its actions are putting hundreds of
3 individuals at serious risk of harm or death.

4 I declare under penalty of perjury and under the laws of the United States, pursuant
5 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
6 knowledge, memory, and belief.

7 Executed on June 22, in the year 2020, in the city of Birmingham, Alabama.

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11 Jessica Myers Vosburgh
12 Adelante Alabama Worker
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13
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15 **UNITED STATES DISTRICT COURT**
16 **CENTRAL DISTRICT OF CALIFORNIA**
17 **EASTERN DIVISION – RIVERSIDE**

18 FAOUR ABDALLAH FRAIHAT, *et al.*,
19 Plaintiffs,
20 v.

21 U.S. IMMIGRATION AND CUSTOMS
22 ENFORCEMENT, *et al.*,
23 Defendants.
24
25
26
27
28

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF JULIE
PASCH**

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26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

DECLARATION OF JULIE PASCH

I, Julie Pasch, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

Background

1. My name is Julie Pasch. I serve as the Managing Attorney for Deportation Defense Houston. Deportation Defense Houston (hereinafter DDH), a project of the Houston Immigration Legal Services Collaborative, is a cohort of three nonprofit legal services providers and one law school clinic that provides *pro bono* legal representation in removal proceedings to people detained by Immigration and Customs Enforcement in the Houston area.
2. DDH provides legal services at all four Houston-area detention facilities: the Houston Contract Detention Facility (Houston Processing Center) in Houston, Texas (“HPC”); the Joe Corley Detention Facility in Conroe, Texas (“Joe Corley”), the Montgomery Processing Center in Conroe, Texas (“MPC”), and the IAH Polk Adult Detention Facility (IAH Secure Adult Detention Center) in Livingston, Texas (“IAH”).
3. Since the outbreak of the COVID-19 pandemic, the four DDH attorneys and three legal assistants have been in regular contact with clients and potential clients at all four Houston-area detention facilities, and they have shared the information they’ve gathered with me. At the beginning of the pandemic, DDH met with clients using non-contact visitation; since the situation in the detention facilities and the Houston area more broadly has deteriorated, all our client and potential client contact has been via telephone. Currently, we do most work through pre-scheduled confidential legal calls, though we also communicate with clients and potential clients through non-legal calls and via mail on occasion.

1 4. I am familiar with the Fraihat subclasses pursuant to the April 20, 2020
2 order.

3 **Custody Redetermination Requests**

4 5. Based on DDH's knowledge and understanding, ICE is not conducting
5 individualized custody determination requests pursuant to the April 20, 2020
6 order.

7 6. As of June 16, 2020, our staff have filed custody redetermination requests
8 for 2 individuals at Joe Corley specifically stating that our clients are
9 members of a Fraihat subclass. This facility is under the Houston Field
10 Office.

11 7. Our first request was submitted on approximately June 3 for a client
12 diagnosed with a heart condition, specifically a heart murmur due to a
13 problem with his mitral valve. Our request included some medical records
14 from the client's country of origin along with standard parole request
15 material such as a sponsor letter and proof of sponsor's income, legal status,
16 and place of residence. This client is not subject to mandatory detention but
17 is not eligible for bond from the Immigration Court because he is charged as
18 an arriving alien. To date, his attorney has not received a response from ICE
19 on this request, although the client has said he was told the request was
20 denied. The client was not given any reason for the denial.

21 8. The above client told his attorney that he was given an EKG and an
22 echocardiogram while in custody. The client has also stated that ICE asked
23 him for a copy of previous echocardiogram and EGK results from medical
24 tests the client took in his country of origin. The client was instructed by
25 facility medical staff to request a medical appointment when he felt
26 symptoms related to his medical condition, such as shortness of breath or
27 arrhythmia (rapid heartbeat) , but he has been unable to visit medical while
28

1 his symptoms are occurring because it takes at minimum three days for a
2 medical visit request to be approved.

3 9. Our second request was submitted on June 4, 2020 for a client suffering
4 from hypertension, high blood pressure, and a heart condition. To date, we
5 have not received a response to this request, but an ICE Deportation Officer
6 (“DO”) informed the client’s attorney during a followup phone call that the
7 request would likely be denied. This officer stated that all COVID-19-
8 related release requests required the facility’s medical staff to approve; if the
9 medical staff said the client was not particularly vulnerable to COVID-19,
10 the client would not be released. The DO insinuated that the client was
11 misrepresenting her medical condition to explain why the fact that medical
12 staff needed to approve meant that the client’s request would *likely be*
13 *denied*.

14 10. During that same call, the above DO also explained that release requests
15 need to be approved by various ICE personnel up the chain of command. He
16 explained that there were significant delays in this process as the current
17 Houston Field Office Director (“FOD”), Daniel Bible, has only recently
18 been appointed and is still familiarizing himself with local procedures. The
19 DO requested supplemental information on the client’s sponsor, which the
20 attorney provided to him.

21 **Conditions of Detention**

22
23 11. As of June 16, 2020, our staff have confirmed that people with risk factors
24 at HPC, Joe Corley, and MPC detention centers are not being provided with
25 sufficient room to practice social distancing. DDH does not currently
26 represent anyone detained at IAH but the individuals we have recently
27 represented at that facility within the past month voiced similar complaints.
28

- 1 12. Clients have reported that they still do not have access to sufficient soap,
2 hand sanitizer or cleaning supplies to wash themselves and their living areas.
- 3 13. Clients have reported that they are being confined 22 or 23 hours a day to
4 their cells. Our clients at MPC have shared that the majority of the dorms at
5 that facility are on lockdown.
- 6 14. Clients at all four Houston-area detention facilities have reported that most
7 of the information they receive about COVID-19 comes from television
8 news and rumors within the facilities. Neither ICE nor the facility staff
9 provide updates about suspected or confirmed cases. This lack of
10 information has caused our clients and potential clients significant stress and
11 anxiety, as they do not know whether they have been exposed to COVID-19
12 or whether a person in their “pod” (dormitory) is sick with COVID-19 or a
13 different illness.
- 14 15. Clients have reported that new people continue to arrive at Joe Corley
15 detention center as recently as May 15. People are being transferred from
16 other detention centers, from jails and from prisons.
- 17 16. DDH legal staff has heard that as of June 16, 2020, staff and detainees are
18 still not regularly wearing surgical masks. Clients detained at HPC have told
19 us they receive two masks per month and must reuse them. Clients at MPC
20 are concerned because the facility staff members that escort detainees and
21 work in common areas such as the kitchen are not wearing masks.
- 22 17. DDH is aware of people who are still being detained at Joe Corley who are
23 elderly or immunocompromised due to diabetes, high blood pressure, and
24 other underlying medical conditions that put them at high risk of contracting
25 and suffering deadly consequences from COVID-19. Joe Corley has not
26 released them despite ICE directives to release medically vulnerable people
27 and the elderly.
- 28 18. DDH knows individuals detained at IAH and Joe Corley who are exhibiting
symptoms of COVID-19. As of June 16, 2020, detained individuals from all

1 four Houston-area facilities report being sick or witnessing other people with
2 coughs, chills, fevers, and other symptoms and report that they were
3 receiving minimal to no medical treatment.

4 19. One DDH client who tested positive for COVID-19 while at Joe Corley was
5 held in medical isolation, but was released from quarantine and sent back to
6 general population without being given a second test. This client reported
7 that he was aware of several others at Joe Corley who were also released
8 from quarantine without a second test.

9 20. DDH knows of individuals at Joe Corley who are witnessing other people in
10 their dorms exhibit symptoms of COVID-19, but neither the symptomatic
11 detainees nor our clients, who have potentially been exposed, have been
12 tested for the virus.

13 21. We have received referrals for several potential clients who we have been
14 told have tested positive for COVID-19. In at least one instance, we have
15 not been able to schedule a confidential attorney phone call with an
16 individual because he is in medical isolation. Facility staff would not
17 disclose additional information, but we believe this is due to a positive
18 COVID-19 test because the referral we received stated he had tested
19 positive.

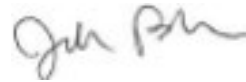
20 22. A local attorney representing someone at MPC shared with DDH staff that
21 his client recently tested positive for COVID-19. However, despite that
22 positive test, the client remained scheduled to be deported to his country of
23 origin. We do not know if the deportation in fact occurred.

24 23. I, along with the other members at DDH, are extremely concerned by ICE's
25 response to the pandemic. We fear for the safety and well-being of the
26 detained individuals at the facilities we serve. We continue to be deeply
27 frustrated and horrified by the lack of efforts ICE and its contractors have
28

1 made to release vulnerable people and ensure safe conditions for those that
2 remain in their custody. We fear that its actions are putting hundreds of
3 individuals at serious risk of harm or death.

4
5 I declare under penalty of perjury and under the laws of the United States, pursuant
6 to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my
7 knowledge, memory, and belief.

8
9 Executed on the 24th of June in the year 2020, in the city of Houston, Texas.

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14 Julie Pasch, Esq.
15 Deportation Defense Houston
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