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***Application for admission pro hac vice forthcoming*

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

O.M.G. and H.G.M., a minor;¹ C.L. and J.A., a minor;
M.C. and G.L.C., a minor; A.H.R. and J.H.R., a
minor; N.V. and Z.F., a minor; R.S.J. and S.A., a
minor; A.L.M. and A.M.M., a minor; G.A.Q. and
minors N.N.A. and A.A.Q.; N.M.L. and A.R.M., a
minor; M.R.A. and L.C.R., a minor; J.S.P. and
M.A.S., a minor; K.N.E. and E.A.N., a minor; K.P.P.
and minors M.P.P. and I.P.P.; M.C.M. and S.M.C., a
minor; C.C.G. and E.C.G., a minor; B.C.A. and
G.S.C., a minor; S.J.A. and W.A.A., a minor; O.T.G.
and T.T.G., a minor; M.J.P. and minors A.M.P.,
A.P.P. and C.P.P.; J.C. and Y.C., a minor; C.R.R. and
minors V.G.R. and I.G.R.; A.C.O. and J.S.O., a minor;
M.A.M. and G.M.A., a minor; J.M.R. and C.G.M., a
minor; R.P.F. and J.F.P., a minor; M.R.C. and M.E.C.,
a minor; B.G.C. and S.M.G., a minor; C.A.M. and
A.P.A., a minor; M.A.H. and I.M.A., a minor; and

Physical Address:

South Texas Family Residential Center
300 El Rancho Way
Dilley, TX 78017; and

Case No. 1:20-cv00786

**EMERGENCY VERIFIED
PETITION FOR A WRIT OF
MANDAMUS AND
COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

¹ This Petition is concurrently filed with a Motion to Proceed Under Pseudonyms due to the fact that all Plaintiffs are seeking protection from persecution and torture in their home countries.

M.B.G., M.H.H. and A.B.H., a minor; C.V.S., S.V.S., and minors J.B.S., R.B.V., J.V.V.-1, J.V.V.-2. and N.V.V.; B.P., K.G.D. and E.P.G., a minor; and

Physical Address:

Berks County Residential Center
1040 Berks Rd
Leesport, PA 19533;

R.M. and V.P., a minor; A.R., T.F. and minors B.F.R. and D.F.R.; A.G.V., A.M.G. and minors A.G.M.-1, A.G.M.-2, and A.G.M.-3; G.R.D., B.N.P., and minors M.R.N., I.R.N., and N.R.N.; A.A.G., L.M.V., and S.A.M, a minor,

Physical Address:

Karnes County Family Residential Center
409 FM1144
Karnes City, TX 78118

Petitioners,

v.

Chad WOLF, in his official capacity as the acting Secretary of the U.S. Department of Homeland Security; and

Physical Address:

Office of the General Counsel
U.S. Department of Homeland Security
Washington, D.C. 20528;

William BARR, in his official capacity as the Attorney General of the United States,

Physical Address:

Office of the Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W., Washington,
D.C. 20530-0001,

Respondents.

PRELIMINARY STATEMENT

1. This case presents the question of whether the government can recklessly expose Petitioners – non-citizen parents and their children detained in purported civil immigration family detention – to conscious shocking risk of exposure to contracting the deadly COVID-19

virus in the midst of a global pandemic by failing to take the mostly minimally precautions to prepare for the all too foreseeable catastrophe in crowded family detention. The answer is no.

2. The novel coronavirus that causes COVID-19 has led to a global pandemic. In only a few months, 306,677 people worldwide have been diagnosed with COVID-19 and over 13,017 have died. Despite repeated, advanced and continued warnings about COVID-19,² Respondents have failed to minimally prepare for and provide for the health and safety of Petitioners – non-citizen parents and children detained in the three Immigration and Customs Enforcement (“ICE”) detention facilities exclusively holding migrant family units in the United States: Berks County Residential Center in Leesport, Pennsylvania; South Texas Family Residential Center in Dilley, Texas; Karnes County Family Residential Center in Karnes City, Texas (collectively, “FRCs”).

3. The Petitioners (the “families”) in this matter are mothers, fathers and minor children who have been placed in purportedly civil detention in a family residential center, a communal space for families seeking asylum in the United States. They are unfortunately in this placement as a pandemic spreads around them. The families are trapped and at risk of serious irreparable physical harm. Their placement in family detention has created a dangerous situation that imminently threatens their lives, the lives of those in the surrounding communities, and the general public should a COVID-19 crisis spark within family detention.

4. Families in FRCs are scared and concerned for their lives. Their legal services providers share the families’ concerns. No minimally sufficient measures have been taken by the Respondents to ensure their care and safety, if that is even possible in the context of the FRCs.

² As of March 21, 2020 at 7:06 p.m. EST. See *COVID-19 CORONAVIRUS PANDEMIC*, WORLDOMETER (Mar. 21, 2020), <https://www.worldometers.info/coronavirus/>.

5. The only known effective measures to reduce the risk of COVID-19 are education, social distancing and improved hygiene. *See* Exh. 12, Declaration of Dr. Ronald Waldman at ¶ 7 (“There is no specific cure or medical countermeasure for COVID-19. Only non-pharmaceutical interventions are available to slow its spread and to mitigate the serious consequences that result from it. The most important of these is commonly termed “social distancing.”); Exh. 14, Letter to Congress Profs. Allen and Rich at 4 (“social distancing is essential to slow the spread of the coronavirus to minimize the risk of infection and to try to reduce the number of those needing medical treatment from the already-overwhelmed and inadequately prepared health care providers and facilities. However, social distancing is an oxymoron in congregate settings”); Exh. 13, Declaration of Dr. Julia DeAun Graves at ¶¶ 2 & 5. Communities have utilized concepts like “shelter in place” and household self-quarantines, which are impossible for the families. Respondents have failed to provide education to Petitioners and individuals employed at the FRCs, ensure that minimum basic necessities such as soap or hand sanitizer are provided, and ensure that is possible to achieve the critical need for social distancing. *See* Exh. 16, Declaration of O.M.G. at ¶ 11 (“The guards have not given us any information about the disease, or how we can protect ourselves from getting it. The jail has not increased our access to hand soap or hand sanitizer, and there are no new efforts to ensure everyone detained here washes their hands. I have not seen any heightened cleaning procedures. The contracted cleaners clean my dorm room once a week. Detained families are required to do the additional cleaning. However, we are not given supplies other than a broom.”); Exh. 2, Declaration of Bridget Cambria at ¶ 28 (inadequate access to soap); Exh. 4, Declaration of M.B.G. at ¶ 7; Exh. 4 (same), Declaration of Shalyn Fluharty at ¶¶ 18, 22 (70.4% of families

stated they had not been provided with additional soap or hand); Exh. 8, Declaration of Julia Valero at 8; Exh. 11, Declaration of T.F. at ¶ 7.

6. The novel coronavirus that causes COVID-19 has caused a global pandemic.³ In only a few months, more than 306,677 people worldwide have received confirmed diagnoses of COVID-19, and over 13,017 of those people have died.⁴ In the United States alone, 25,896 cases of infection have been reported and 316 people have died.⁵ The disease itself does not discriminate between the old and young, and people of all ages, with and without preexisting conditions, have died.⁶ All 50 states have reported cases of COVID-19 infection.⁷ There is no vaccine against COVID-19, and there is no known cure. No one and no place is immune.

7. The Centers for Disease Control and Prevention (“CDC”) reports that “[t]he best way to prevent illness is to avoid being exposed to this virus.”⁸ The CDC advises that COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6 feet) and through respiratory droplets caused when someone coughs or sneezes.⁹

³ World Health Organization, Rolling updates on coronavirus disease (COVID-19) (Updated Mar. 20, 2020) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>.

⁴ As of March 21, 2020 at 7:06 p.m. EST. See *COVID-19 CORONAVIRUS PANDEMIC*, WORLDOMETER (Mar. 21, 2020), <https://www.worldometers.info/coronavirus/>.

⁵ *Id.*

⁶ As of March 21, 2020 at 3:10p.m. EST. See *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*, CDC COVID-19 Response Team (Mar. 18, 2020) https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w; As of March 21, 2020 at 3:18 p.m. EST. See *34-Year-Old Man Who Died After Getting Coronavirus Had Visited Disney World*, Rachel Olding (Mar. 19, 2020) <https://www.thedailybeast.com/california-man-age-34-who-died-after-contracting-coronavirus-had-visited-disney-world-and-universal-studios>.

⁷ As of March 21, 2020 at 3:20 p.m. EST. See *Situation Summary* (Mar. 18, 2020) https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html.

⁸ As of March 21, 2020 at 3:20 p.m. EST. See *How to Protect Yourself* (Mar, 2020) <https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>.

⁹ *Id.*

8. States have taken extraordinary and unprecedented measures to ensure that their citizens practice “social distancing” in order to halt the spread of COVID-19. On March 19, 2020, Governor Gavin Newsom of California ordered 40 million Californians to stay in their houses or their places of residence; on March 20, 2020, Governor J.B. Pritzker issued a similar order for the State of Illinois.¹⁰ New York, New Jersey and Connecticut have banned gatherings of more than 50 people, closed gyms and casinos, and restaurants and bars are only allowed to provide take-out or delivery services.¹¹ On March 19, 2020, Governor Tom Wolf on Pennsylvania issued a sweeping shutdown order to tens of thousands of “non-life-sustaining” businesses.¹² Numerous states have closed schools for at least one month, and Kansas has ordered that schools will not reopen for the remainder of the 2019-2020 school year.¹³

9. The criminal detention facilities in San Antonio, Texas and Berks, Pennsylvania have released prisoners out of concerns for their well-being and to decrease the spread of COVID-19.¹⁴

10. The consensus in the medical community is that the COVID-19 epidemic will escalate dramatically in the coming months. Hospitals around the country are already running

¹⁰ As of March 21, 2020 at 3:28 p.m. EST. See Coronavirus (COVID-19) in California. California Coronavirus (COVID-19) Response. (Mar. 2020). <https://covid19.ca.gov/>; As of March 21, 2020 at 3:31 p.m. EST. See Executive Order in Response to COVID-19. State of Illinois. March 20, 2020. <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-10.pdf>.

¹¹ As of March 21, 2020 at 3:33 p.m. EST. See *10 States With the Most Aggressive Response to COVID-19*. U.S. News and World Report. (March 17, 2020). <https://www.usnews.com/news/best-states/articles/2020-03-17/10-states-with-the-most-aggressive-response-to-coronavirus>

¹² As of March 21, 2020 at 3:38 p.m. EST. See Gov. Wolf delays enforcement of order closing 'non-life-sustaining' businesses amid COVID-19 <https://6abc.com/health/gov-wolf-orders-1000s-of-businesses-to-shut-down-over-virus/6031024/>.

¹³ As of March 21, 2020 at 3:39 p.m. EST. See Some schools closed for coronavirus in US are not going back for the rest of the academic year. CNN. (March 18, 2020). <https://www.cnn.com/2020/03/18/us/coronavirus-schools-not-going-back-year/index.html>.

¹⁴ See <https://www.expressnews.com/news/local/article/Sheriff-quarantines-11-deputies-releases-more-15144847.php> and https://www.wfmz.com/health/coronavirus/berks-jail-freeing-some-inmates-in-effort-to-avoid-virus/article_7d3229c8-69ea-11ea-a960-8b97f5a94d08.html

out of medical supplies.¹⁵ The projections for those who contract the virus and those who succumb to the illness are startling and grave. The CDC suggested that between 160 million and 210 million Americans could contract the disease over as long as a year. Based on mortality data and current hospital capacity, the number of deaths under the CDC's scenarios ranged from 200,000 to as many as 1.7 million...It found as many as 21 million people might need hospitalization, a daunting figure in a nation with just about 925,000 hospital beds."¹⁶

11. Despite the directives from the CDC, the extraordinary measures being taken by the States to ensure social distancing, and the lack of adequate medical supplies, Respondents have failed to protect one of the most vulnerable populations in their charge: noncitizen asylum-seeking families in family detention.

12. Notably, on March 19, 2020, both ICE and the Office of Refugee Resettlement ("ORR") reported their first cases of COVID-19 in detention centers they run: a member of the medical staff of an ICE adult detention facility, and a staff member of an ORR detention center for unaccompanied minors. ¹⁷ Currently, thousands of non-citizen parents and minor children are being detained in the three FRCs. Many mothers, fathers and children have been detained well prior to the start of the pandemic and many have recently been detained. All of the families are at risk at present, and their situation presents a grave situation, a tinderbox, that once sparked

¹⁵ As of March 21, 2020 at 3:39 p.m. EST. *See* Hospital Workers Make Masks From Office Supplies Amid U.S. Shortage. Bloomberg News. (March 17, 2020). <https://www.bloomberg.com/news/articles/2020-03-18/hospital-makes-face-masks-covid-19-shields-from-office-supplies>

¹⁶ As of March 21, 2020 at 3:42 p.m. EST *See* Worst-case coronavirus models show massive US toll. The Hill. (March 13, 2020). <https://thehill.com/homenews/state-watch/487489-worst-case-coronavirus-models-show-massive-us-toll>

¹⁷ As of March 21, 2020 at 3:45 p.m. EST *See* ICE medical staff member tests positive for COVID-19. The Hill. (March 19, 2020). <https://thehill.com/policy/healthcare/488568-ice-medical-staff-tests-positive-for-covid-19>; As of March 21, 2020 at 3:45 p.m. EST *See* A Staff Member At A Facility Housing Unaccompanied Immigrant Children Has Tested Positive For The Coronavirus. BuzzFeed News. Hamed Aleaziz. (March 19, 2020) <https://www.buzzfeednews.com/article/hamedaleaziz/staff-member-coronavirus-diagnosis-unaccompanied-immigrant>

will create a crisis that threatens the lives of the women, men and children who are detained in family residential centers. *See e.g.* Exhs. 2 (Declaration of Bridget Cambria), 4 (Declaration of Shalyn Fluharty), 7 (Declaration of Andrea Meza).

13. FRCs are congregate environments, in which the families live, eat, and sleep in close proximity. *See* Exh. 2, Declaration of Bridget Cambria at ¶¶ 9-18; Exh. 4, Declaration of Shalyn Fluharty at ¶¶ 6-18; Exh. 7, Declaration of Andrea Meza at ¶ 35. Thus, detainees in FRCs face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships and nursing homes. *Id.* For that reason, “Doctors, lawyers, asylum-seekers and former officials are urging the Trump administration to release thousands of immigrants from detention to avoid a potentially deadly corona virus outbreak in scores of facilities across the country.”¹⁸ “‘It’s a vulnerable situation,’ John Sandweg, an acting head of ICE during the Obama administration, told CBS News. ‘You have the exact situation everyone is cautioning against. You have a bunch of people contained in a very small environment.’...‘[c]an you imagine if you get an outbreak in these detention facilities? It’s going to spread like wildfire,’ Sandweg added.”¹⁹

14. Family Residential Centers are reserved for those asylum-seeking families who are not in criminal proceedings, do not pose a danger to the community, and are simply civil detainees. For that reason, residential centers, different from conventional high security prisons, encourage comingling of all detainees regardless of age, genders, or other vulnerable trait.

15. The three primary legal service providers that give legal assistance to the detainees in the FRCs—the Refugee and Immigrant Center for Education and Legal Services

¹⁸ As of March 21, 2020 at 3:48 p.m. EST *See* “Powder kegs”: Calls grow for ICE to release immigrants to avoid coronavirus outbreak. CBS News. (March 19, 2020).<https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak/>

¹⁹ *Id.*

(“RAICES”), The Dilley Pro Bono Project (“DPBB”), and ALDEA - The People’s Justice Center (“ALDEA”)—all report that in their visits to the FRCs in the past week, they have observed and learned that the FRCs are not following CDC guidelines to prevent the spread of COVID-19:

- Social distancing—keeping a distance of 6 feet—is impossible, as detainees are surrounded by tens to hundreds of other detainees at any given time, sharing bedrooms, bathrooms, and communal spaces;
- The FRCs do not have instructions on how to maintain hygiene (wash hands, sanitize hands, stay 6 feet apart);
- The detainees are not provided hand sanitizer;
- Detainees do not have consistent access to soap, and are often required to purchase soap themselves;
- Detainees are not provided protective masks or gloves;
- Guards and staff working at the FRCs, in the common areas and cafeteria, do not use masks or gloves, do not abide by the 6 feet social distancing rule, and still shake hands, and;
- Hundreds of families in the FRCs are exhibiting symptoms of COVID-19, including coughs, fever, shortness of breath, but are not being tested for COVID-19, or getting adequate medicine to address these symptoms.

See Exhs. 2, Declaration of Bridget Cambria; Exh. 3, Declaration of M.B.G.; Exh. 4, Declaration of Shalyn Fluharty; Exh. 5, Declaration of Allison Herre; Exh. 6, Declaration of Stephanie Alvarez-Jones; Exh. 7, Declaration of Andrea Meza; Exh. 8, Declaration of Julia Valero; Exh. 9, Declaration of Laila Ayub; Exh.10, Declaration of R.P.; Exh. 11, Declaration of T.F.; Exh. 16, Declaration of O.M.G.; Exh. 17, Declaration of C.L.

16. Numerous experts in the field of infectious disease and public health warn that to contain the unchecked spread of the COVID-19 virus, Respondents must relocate as many people as possible out of these institutional settings. *See e.g.* Exh. 12, Declaration of Dr. Ronald

Waldman at ¶¶ 7-11; Exh. 13, Declaration of Dr. Julia DeAun Graves at ¶ 5-12; Exh. 14, Letter to Congress Profs. Allen and Rich; Exh. 15, Declaration of Dr. Jaimie Meyer at ¶¶ 7-35.

17. Upon information and belief, although Respondents have begun to release some families—those that include pregnant women or people who suffer from asthma—at the Karnes and Dilley FRCs, the remaining families continue to suffer from Respondents continued failures. If Respondents do not take immediate and drastic steps to protect their detainees, utilize applicable policies and laws, require social distancing for each and every family, to provide every individual sanitizers and soap, to ensure adequate medical capability and resources for all detained families, FRCs will become sites of massive numbers of COVID-19 cases placing both people held there, as well as those who work there and the public at large, at high risk of infection and death. *See id.*

18. The FRCs have failed to implement adequate protocols to protect Petitioners and all migrant family detainees from COVID-19. *See* Exhs. 2, Declaration of Bridget Cambria; Exh. 4, Declaration of Shalyn Fluharty; Exh. 5, Declaration of Allison Herre; Exh. 6, Declaration of Stephanie Alvarez-Jones; Exh. 7, Declaration of Andrea Meza; Exh. 8, Declaration of Julia Valero; Exh. 9, Declaration of Laila Ayub. Their failures risk the lives of the families Respondents have chosen to detain, and those failures threaten the general public as well.

19. If even one detainee were to contract COVID-19, a spread throughout the facility would be impossible to contain and would threaten the lives and general welfare of the detained family population and the public at large. The residential centers cannot sustain the risk, the surrounding communities cannot sustain the risk, and the threat to the health systems in areas with FRCs is unimaginable. *See* Exh. 14, Letter to Congress Profs. Allen and Rich at p. 4 (“This then creates an enormous public health risk, not only because disease can spread so quickly, but

because those who contract COVID-19 with symptoms that require medical intervention will need to be treated at local hospitals, thus increasing the risk of infection to the public at large and overwhelming treatment facilities.”)

PARTIES

20. Petitioners O.M.G. (a mother), and H.G.M. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

21. Petitioners C.L. (a mother) from Haiti and J.A. (a child) from Brazil are in civil immigration detention as a family unit at the South Texas Family Residential Center.

22. Petitioners M.C. (a mother) from Haiti and G.L.C. (a child) from Chile are in civil immigration detention as a family unit at the South Texas Family Residential Center.

23. Petitioners A.H.R. (a mother) and J.H.R. (a child) from Guatemala are in civil immigration detention as a family unit at the South Texas Family Residential Center.

24. Petitioners N.V. (a mother) from Haiti and Z.F. (a child) from Brazil are in civil immigration detention as a family unit at the South Texas Family Residential Center.

25. Petitioners R.S.J. (a mother) and S.A. (a child) from Haiti are in civil immigration detention as a family unit at the South Texas Family Residential Center.

26. Petitioners A.L.M. (a mother) and A.M.M. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

27. Petitioners G.A.Q. (a mother) and children N.N.A. and A.A.Q. from El Salvador are in civil immigration detention as a family unit at the South Texas Family Residential Center.

28. Petitioners N.M.L. (a mother) and A.R.M. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

29. Petitioners M.R.A. (a mother) and L.C.R. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

30. Petitioners J.S.P. (a mother) and M.A.S. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

31. Petitioners K.N.E. (a mother) and E.A.N. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

32. Petitioners K.P.P. (a mother) and children M.P.P. and I.P.P. from Ecuador are in civil immigration detention as a family unit at the South Texas Family Residential Center.

33. Petitioners M.C.M. (a mother) and S.M.C. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

34. Petitioners C.C.G. (a mother) and E.C.G. (a child) from El Salvador are in civil immigration detention as a family unit at the South Texas Family Residential Center.

35. Petitioners B.C.A. (a mother) and G.S.C. (a child) from Ecuador are in civil immigration detention as a family unit at the South Texas Family Residential Center.

36. Petitioners S.J.A. (a mother) and W.A.A. (a child) from Guatemala are in civil immigration detention as a family unit at the South Texas Family Residential Center.

37. Petitioners O.T.G. (a mother) and T.T.G. (a child) from Guatemala are in civil immigration detention as a family unit at the South Texas Family Residential Center.

38. Petitioners M.J.P. (a mother) and children A.M.P., A.P.P. and C.P.P. from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

39. Petitioners J.C. (a mother) and Y.C. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

40. Petitioners C.R.R. (a mother) and children V.G.R. and I.G.R. from Mexico are in civil immigration detention as a family unit at the South Texas Family Residential Center.

41. Petitioners A.C.O. (a mother) and J.S.O. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

42. Petitioners M.A.M. (a mother) and G.M.A. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

43. Petitioners J.M.R. (a mother) and C.G.M. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

44. Petitioners R.P.F. (a mother) and J.F.P. (a child) from El Salvador are in civil immigration detention as a family unit at the South Texas Family Residential Center.

45. Petitioners M.R.C. (a mother) and M.E.C. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

46. Petitioners B.G.C. (a mother) and S.M.G. (a child) from Guatemala are in civil immigration detention as a family unit at the South Texas Family Residential Center.

47. Petitioners C.A.M. (a mother) and A.P.A. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

48. Petitioners M.A.H. (a mother) and I.M.A. (a child) from Honduras are in civil immigration detention as a family unit at the South Texas Family Residential Center.

49. Petitioners M.B.G. (a father), M.H.H. (a mother), and A.B.H. (a child) from El Salvador are in civil immigration detention as a family unit at the Berks County Residential Center.

50. Petitioners C.V.S. (a father), S.V.S. (a mother), and children J.B.S., R.B.V., J.V.V.-1, J.V.V.-2 and N.V.V. from El Salvador are in civil immigration detention as a family unit at the Berks County Residential Center.

51. Petitioners B.P. (a father), K.G.D. (a mother) and E.P.G. (a child) from Mexico are in civil immigration detention as a family unit at the Berks County Residential Center.

52. Petitioners R.P. (a father), R.M. (a mother) and V.P. (a child) from Haiti are in civil immigration detention as a family unit at the Karnes County Family Residential Center.

53. Petitioners A.R. (a father), T.F. (a mother) from Haiti, and their two children B.F.R. and D.F.R. from Brazil are in civil immigration detention as a family unit at the Karnes County Family Residential Center.

54. Petitioners A.G.V (a father), A.M.G (a mother), and their three children A.G.M.-1, A.G.M.-2, and A.G.M.-3 from Mexico are in civil immigration detention as a family unit at the Karnes County Family Residential Center.

55. Petitioners G.R.D. (a father), B.N.P. (a mother), and their three children M.R.N., I.R.N., and N.R.N from Mexico are in civil immigration detention as a family unit at the Karnes County Family Residential Center.

56. Petitioners A.A.G (a father), L.M.V. (a mother), and S.A.M from Mexico are in civil immigration detention as a family unit at the Karnes County Family Residential Center.

57. Respondent, Chad Wolf, is named in his official capacity as the acting Secretary of the U.S. Department of Homeland Security. Respondent Wolf is responsible for enforcing federal laws concerning, for example, border control and immigration, including the INA provisions at issue in this case. Respondent Wolf has direct authority over the Immigration and Customs Enforcement (“ICE”) agency which is responsible for the civil detention of immigrants in the United States. Respondent Wolf routinely transacts business in the District of Columbia, and maintains offices in this judicial district. Respondent Wolf’s address is: U.S. Department of Homeland Security, Washington, DC 20528.

58. Respondent, William Barr, is named in his official capacity as the Attorney General of the United States. In this capacity, he is responsible for the administration of the immigration laws as exercised by the Executive Office for Immigration Review. Respondent Barr routinely transacts business in the District of Columbia. Respondent Barr's address is: Attorney General of the United States, U.S. Department of Justice, 950 Pennsylvania Avenue, N.W., Washington, District of Columbia 20530.

VENUE

59. Venue in the District Court for the District of Columbia is proper under 28 U.S.C. § 1391(b) because Respondents reside in this District.

JURISDICTION

60. Respondents reside within the jurisdiction of this Court.

61. This case arises under the United States Constitution; the Administrative Procedure Act ("APA"), the Flores Settlement Agreement ("FSA"), a consent decree which is effectively a contract to which the United States government is a party and of which the minor Petitioners are protected class members, and federal common law.

62. This Court has jurisdiction pursuant to The All Writs Act, 28 U.S.C. § 1651(a).

63. This Court has jurisdiction pursuant to 28 U.S. Code § 1331 (Federal Question), 28 U.S. Code § 1361 (Action to compel an officer of the United States to perform his duty) and 28 U.S.C. § 2201(a), (Federal Declaratory Judgement Act).

FACTS

I. The COVID-19 Global Pandemic

64. COVID-19 is a highly infectious and deadly coronavirus that, according to the World Health Organization, is a global pandemic. *See* Exh. 13, Declaration of Dr. Julia DeAun Graves at ¶ 2.

65. There is currently no vaccine to prevent (COVID-19) from infecting an individual. *See* Exh. 12, Declaration of Dr. Ronald Waldman at ¶ 7.

66. The CDC states that “[t]he best way to prevent illness is to avoid being exposed to this virus.”

67. COVID-19 appears to be spreading easily and sustainably in the community (“community spread”) in some affected geographic areas.

68. Currently, all 50 states are reporting COVID-19 cases.

69. The CDC advises that COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6 feet). *See* Exh. 12, Declaration of Dr. Ronald Waldman at ¶ 7.

70. It spreads through respiratory droplets produced when an infected person coughs or sneezes. *See* Exh. 13, Declaration of Dr. Julia DeAun Graves at ¶ 6.

71. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

72. Per the CDC, people are thought to be most contagious when they are most symptomatic (the sickest) and spread might be possible before people show symptoms.

73. The CDC states that it may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or eyes.

74. It had initially been reported that people over the age of fifty, pregnant women, and those with certain medical conditions face a greater chance of serious illness or death from COVID-19.

75. However, in a CDC report dated March 18, 2020, it was noted that while the oldest patients had the greatest likelihood of dying and of being hospitalized, 38 percent of the 508 hospitalized patients were notably younger—between 20 and 54. *See Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* (Mar. 18. 2020)

https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

76. Medical conditions that increase the risk of serious COVID-19 disease for people of any age include: lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, and developmental delay. *See* Exh. 13, Declaration of Dr. Julia DeAun Graves at ¶ 3.

77. Nearly half of the 121 patients who were admitted to intensive care units were adults under 65. *See Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* (Mar. 18. 2020)

https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

78. As noted above, there is no vaccine against COVID-19, and there is no known cure. The COVID-19 virus can cause severe damage to lung tissue, sometimes leading to a permanent loss of respiratory capacity, and can damage tissues in other vital organs including the heart and liver.

79. Patients with serious cases of COVID-19 require advanced medical support, including positive pressure ventilation and extracorporeal mechanical oxygenation in intensive care, while patients who do not die from serious cases of COVID-19 may face prolonged

recovery periods, including extensive rehabilitation from neurologic damage and loss of respiratory capacity. *See* Exh. 15, Declaration of Dr. Jaimie Meyer at ¶ 22.

80. The only known effective measures to reduce the risk for vulnerable people of serious illness or death caused by COVID-19 are social distancing and improved hygiene, which have led to unprecedented public health measures around the world. According to preliminary data from China, 20 percent of people in high risk categories who contracted COVID-19 there died. *See* Exh. 12, Declaration of Dr. Ronald Waldman at ¶ 7.

81. People in congregate environments, which are places where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships and nursing homes. *See* Exh. 14, Letter to Congress Profs. Allen and Rich at 4.

82. People who are confined in prisons, jails, and detention centers will find it virtually impossible to engage in the necessary social distancing and hygiene required to mitigate the risk of transmission, even with the best-laid plans. *Id.*

83. For this reason, correctional public health experts have recommended the release from custody of people most vulnerable to COVID-19. *Id.* at p. 5 (“Finally, regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, it is essential to consider releasing all detainees who do not pose an immediate risk to public safety.”)

84. As of the date of this Petition, a member of the medical staff at Elizabeth Detention Center in New Jersey had tested positive for coronavirus, the first case confirmed by Immigration and Customs Enforcement of an employee contracting the virus. On information and belief, there are a number of presumptive positive cases of detainees in civil ICE detention.

II. Grave Risks of Contracting COVID-19 in Family Detention Centers

85. Immigration detention facilities are “congregate environments,” or places where people live and sleep in close proximity. Infectious diseases that are communicated by air or touch are more likely to spread in these environments. This presents an increased danger for the spread of COVID-19 if and when it is introduced into a facility. *See id.* at pp. 3-4.

86. Family detention centers are unique centers in the immigration system. It is limited to three locations in the United States: Leesport, Pennsylvania, Karnes City, Texas and Dilley, Texas. These are rural and medically underserved areas of the country. However, they possess the entire family residential structure in the Immigration System. In family residential centers, dozens to hundreds of families congregate every moment of every day, and live, eat and play in small structured environments which make the necessary precautions against the spread of COVID-19 impossible.

87. Other group-like environments, like cruise ships or nursing homes, have become the sites for the most severe outbreaks of COVID-19. The highest known person-to-person transmission rate for COVID-19 took place in a skilled nursing home facility in Kirkland, Washington, and on afflicted cruise ships in Japan and off the coast of California. Family detention is certain akin to a cruise ship – as the detained families are not permitted to leave the facility or grounds. Family detention is also like a nursing home – in fact, the Berks facility is housed in a single building formerly used as a nursing home.

88. The conditions of the family residential centers pose a heightened public health risk for the spread of COVID-19 that is even greater than in non-carceral institutions.

89. Immigration detention facilities have even greater risk of infectious spread because of crowding, the proportion of vulnerable people detained, and often scant medical resources. In fact, it is impossible to ignore that seven children in the Respondent’s care have

perished in immigration detention: they are Sixteen-year-old J.L.G., 7-year-old J.C.M., 8-year-old F.G.A., 2-year-old W.J.R.V., and 16-year-old C.H.V. Another 20-month-old girl, Mariee Juárez, died shortly after being held at the South Texas Family Residential Center at Dilley, TX.²⁰

90. In family residential centers, detained mothers, fathers and children are forced to live and sleep in close quarters and required to congregate and as a result, cannot achieve the “social distancing” needed to effectively prevent the spread of COVID-19. Even in their beds they cannot even sleep or receive the required distance necessary to protect themselves.

91. Families at FRCs are unable to maintain the recommended distance of 6 feet from others and often share or touch objects used by others.

92. In FRCs toilets, sinks, and showers are shared, without disinfection between each use and are used constantly by large numbers of people.

93. Food preparation and service is communal with little opportunity for surface disinfection. Families are required to eat together and only at certain times of the day. The areas where they eat create dangerous situations for the spread of COVID-19.

94. Detention facility staff, ICE staff, medical staff arrive and leave on a shift basis, and there is limited ability to adequately screen staff for new, asymptomatic infection. The ebb and flow of people from family residential centers are constant and wide ranging. Families are transported into the facility from all over the country, ICE staff have contacts with those not only within the facility but multiple detention centers, medical staff contact an innumerable number of

²⁰ As of March 21, 2019 at 3:50p.m. EST. *See* Opinion: Seven Children Have Died In Immigration Custody. Remember Their Names. BuzzFeed News. (September 30, 2019) <https://www.buzzfeednews.com/article/jessmoralesrocketto/remember-their-names>

detained families, and employees come and go from their home and their communities. The risk is great.

95. Family residential centers lack adequate medical infrastructure to address the spread of infectious disease and treatment of people most vulnerable to illness in detention. They are ill prepared to deal with the tragic situation which is likely to unfold. Even DHS medical professionals describe the immigration detention system as a “tinderbox.” Exh. 14 Letter to Congress Profs. Allen and Rich at ¶¶ 4 & 6.

96. All three FRCs rely on the detained civil population as their cleaning staff for the detainee residential areas pursuant to a “voluntary” work program paying \$1 per day and there has been no change to this policy in light of the recent pandemic. This is a huge and genuine risk to the families and children detained, whom are not provided the security of a sanitary living environment to protect from the spread of infection of this highly contagious disease.

97. At some if not all of the FRCs, detained families report that they lack adequate cleaning supplies.

98. During the H1N1 influenza epidemic in 2009, jails and prisons were sites of severe outbreaks. It is impossible to ignore that the majority of the detainees at issue here are children. Children notoriously carry and spread diseases more frequently, given their vulnerability and the nature of children generally. Illnesses spread through family detention centers like wildfires. It is a lack of common sense to believe the COVID-19 pandemic will be any different.

99. Rather it is almost certain to expect COVID-19 to infect and spread rapidly in family residential centers, especially when people cannot engage in proper hygiene or isolate themselves from infected or asymptomatic residents or staff.

100. Indeed, the FRCs are not educating detainees about COVID-19 at all and have failed to implement protocols recommended by the CDC to prevent transmission of COVID-19. Families are relegated to learning about COVID-19 from the news, they are not provided extra necessities to protect themselves, and they are simply awaiting the worst. Family's have expressed terror that they will become sick, will potentially die and will not be able to protect themselves. It is an unacceptable environment and an unnecessary risk. *See e.g.* Exhs. 2 (Declaration of Bridget Cambria), 4 (Declaration of Shalyn Fluharty), 7 (Declaration of Andrea Meza).

A. Berks County Residential Center

101. The detainees at Berks County Residential Center ("Berks Center") have not been briefed on COVID-19 by the staff, by ICE or any other operator of Berks Center, either about the fact that there is global pandemic or what precautions they should be taking to prevent the spread of the virus. *See* Exh. 2, Declaration of Bridget Cambria at ¶ 27; Exh. 3, Declaration of M.B.G. at ¶¶ 8 & 10.

102. Petitioners are aware of COVID-19 only from the news on the television. *See* Exh. 3, Declaration of M.B.G. at ¶ 8.

103. There is a note posted on the outside of the facility that misidentifies the COVID-19 pandemic as the "flu" to the general public and those who enter the building.

104. There is only one sign in Berks Center that instructs detainees in Spanish to wash their hands. The other signs have been seen by legal service providers concerning COVID-19 but are in English.

105. Detainees report that there are new detainees entering the facility and that employees come and go daily, but they have not witnessed any precautions being taken to screen for COVID-19, except that incoming detainees have their temperature taken.

106. New families who have arrived in the past week are coming into the facility being transferred in and many of them have children who are ill with congestion, cough, sore throat and fever. They also demonstrate lethargy, lack of appetite and inability to sleep.

107. Detainees report that numerous parents and children in the facility are sick with cold-like symptoms, such as coughs, congestion and fever.

108. Detainees have observed that numerous staff members are exhibiting similar cold-like symptoms.

109. Despite this fact, when detainees request medicine for their children they are not provided medicine.

110. One mother asked her attorney to ask the staff to provide medicine to her child who had been sick for 4 days without treatment. When the attorney's legal assistant requested cough medicine from a staff member, the staff member replied, "what is cough syrup." When the legal assistant asked the staff member to make a resident request to the facility for cough medicine, the staff member replied that there is no resident request form. To the contrary, the Berks Center handbook contains a section on resident requests, as well as a grievance process for denials of requests. *See* Exh. 2, Declaration of Bridget Cambria at ¶ 32.

111. While the staff is wearing gloves, detainees are not provided gloves unless they participate in a voluntary work program to clean the facility or are cleaning their rooms. *Id.* at ¶ 29.

112. Indeed, the Petitioners at Berks Center observe that it is only cleaned by detainees and shelter care counselors.

113. Neither Petitioners nor the staff have been provided with masks and requests for this protection has been refused. *Id.* at ¶ 29.

114. Petitioners also report concerns with the cleanliness of Berks Center. For example, while the detainees at Berks Center are witnessing the staff wiping down sofas, they describe the staff as spraying bleach water into the air or over tables. Detainees also report that the children's toys are simply sprayed on the top with bleach. When the children play with the toys, they are putting the toys in their mouths.

115. Detainees also report that there are broken soap dispensers in their rooms that have not been fixed despite their requests. *Id.* at ¶ 28.

116. Hand sanitizer is only freely provided in the lobby and legal visitation room at Berks Center -two areas that detainees are not permitted to access. *Id.*

117. Detainees are housed in shared rooms and cannot remain 6 feet apart for social distancing within the constraints of detention. Sleeping quarters are very cramped. *Id.* at ¶¶ 15-18.

118. Detainees report that they are forced to remain in close contact with each other when eating together in the shared cafeteria and when in their shared bedrooms. *Id.*

119. The entire detained population at Berks as well as the staff (approximately 60 people or more) eat at the same time in the cafeteria during mealtime. *Id.* at ¶ 18.

120. The facility continues to receive new families. The operation of the facility remains unchanged. *Id.* at ¶ 31.

B. South Texas Family Residential Center

121. The South Texas Family Residential Center ("Dilley") is an ICE detention facility with capacity to detain up to 2,400 mothers and their minor children at any given time. Approximately 1,000 mothers and children are currently detained in Dilley. *See* Exh. 4, Declaration of Shalyn Fluharty, ¶ 2.

122. Detainees in Dilley have not been provided with COVID-19 education by facility staff, ICE or any other operator at Dilley. Detainees have questions regarding the pandemic, what precautions they can take to keep themselves safe, and what protocols the facility is implementing to prevent the spread of the disease. *See* Exh. 4, Declaration of Shalyn Fluharty; Exh. 16, Declaration of O.M.G.; Exh. 17, Declaration of C.L.

123. Detainees have not been advised they should sneeze or cough into a tissue, or provided with any other hygiene education. Exh. 4, ¶ 22.

124. Detainees are housed in shared trailers, and at any given time are required to share bedrooms, bathrooms, and other communal spaces with unrelated detainees.

125. In order to participate in court proceedings, education, asylum interviews, medical appointments, and attorney meetings, detainees must sit next to other detainees while waiting to be seen. Exh. 4, ¶ 16. Common areas - such as cafeterias, auditoriums for mandatory meetings, and waiting areas to obtain prescribed medication - regularly hold over one hundred people with no possibility of social distancing. *Id.*

126. Despite Texas Governor Abbott ordering all schools to close until April 3, 2020 to limit the spread of coronavirus, children detained in Dilley continue attending school.²¹

127. Dilley staff do not appear to be making any changes to regular, insufficient, cleaning procedures. *See* Exhibit 5, Declaration of Allison Herre, ¶ 11. Detainees report that bathrooms are dirty. Although dormitories are cleaned once a week by janitorial staff, detainees are expected to clean their dormitory throughout the week. Detainees however are not provided with cleaning supplies other than paper towels and a broom, and are deprived of protective gear such as gloves and masks. When detainees request access to additional cleaning supplies, they

²¹ As of March 21, 2020 at 3:13 p.m. *See* Dilley Independent School District, <http://www.dilleyisd.net/>

are told cleaning supplies are in short supply and being rationed. Exh. 4, ¶ 19, 20. Furthermore, while toys are purportedly sanitized three times per day, many detainees reported that this is inconsistent, and is denied when specifically requested.

128. Hand sanitizer is not provided to detainees. Many detainees report that soap dispensers are broken or are simply out of soap. Despite multiple attempts to report these errors, access to soap remains insufficient. Exh. 4, ¶ 18. Exh. 16, ¶ .

129. Facemasks, gloves, and other protective gear are generally not provided to families detained in Dilley. Exh. 4, ¶ 21. Detainees report observing staff coughing without using masks, and that at least one CoreCivic or ICE employee states they returned to work after being diagnosed with COVID-19. *See* Exh. 4, ¶ 21; Exh. 6, ¶ 6; Exh. 16.

130. Medical care is inadequate, with many detainees suffering from asthma, children reporting fevers, pregnant women receiving insufficient prenatal care, and detainees being denied evaluation for undiagnosed medical symptoms and treatment for known pre-existing conditions. Exh. 4, ¶ 24-33. Families report having to wait up until 8 hours to access medical care, and regularly waiting in lines for two to three hours to see a doctor. *Id.*

131. At least one child has died subsequent to release from Dilley after developing an infection that went untreated while in detention. Exh. 4, ¶ 23. Individuals with known pre-existing conditions are not provided any additional measures to protect them COVID-19 infection, such as being isolated or distanced from others detained in the facility. Exh. 4, ¶ 25. Currently there are individuals detained in Dilley with diabetes, thyroiditis, hyper-thyroidism, tooth infections, vitiligo, epilepsy, gastric liver damage, tachycardia, eye infection, chronic gastritis, and seizure disorder, heart palpitations, heart murmurs, deteriorating vision, undiagnosed lumps with accompanying pain and swelling, kidney inflammation and

complications, continued vomiting, severe migraines, numbness in limbs, tumors and ovarian cysts. In addition, there is a child who recently survived a severe skull fracture, a child who is a cancer survivor, and a mother who recently required surgery while detained. *Id.* 33.

132. Large volumes of detainees in Dilley report having a cough or high fever and observing other detainees and facility staff with a cough or high fever. Detainees report they have not been tested for COVID-19, and are unaware of other detainees being tested. Exh. 4, ¶¶ 22, 24.

133. Medical specialists are generally not available on-site in Dilley. Detainees who require specialty or urgent care must be transported to a hospital in San Antonio, Texas – which is approximately one and half hours away from the facility in Dilley. Exh. 4, ¶ 34.

134. Screening for lawyers and legal visitors has not changed—lawyers entering Dilley have not been asked about travel, have not had their temperatures checked, and have not been advised to wash their hands or provided hand sanitizer. Exh. 6, Declaration of Stephanie Alvarez Jones. Although a notice regarding COVID-19 has been posted; it recommends that people with cough or fever not enter Dilley. *Id.*

135. Testing of detainees for COVID-19 has not been made available, with no plans to do so. ICE leadership states that medical screening procedures for families detained in Dilley have not changed in response to the COVID-19 outbreak. Exh. 5, Declaration of Allison Herre, ¶¶ 5-6.

C. Karnes County Residential Center

136. The detainees at Karnes County Residential Center (“Karnes”) have not been briefed on COVID-19 by the staff, by ICE or any other operator of Karnes, either about the fact that there is global pandemic or what precautions they should be taking to prevent the spread of

the virus. Exh. 7, Declaration of Andrea Meza at ¶22; Exh. 10, Declaration of Richard Paquiot at ¶ 2.

137. Officials running Karnes do not have access to COVID-19 tests. Exh. 7, at ¶18.

138. Detainees have recently been asked to sign a “form about coronavirus” but the contents of the form were not explained to them. Exh. 9, Declaration of Laila Ayub at ¶20; Exh. 8, Declaration of Julia Valero at ¶15.

139. Detainees report that they do not have access to hand sanitizer, protective masks, or gloves. Exh. 11, Declaration of T.F. at ¶7; Exh. 8, at ¶7. Detainees have reported that there are no posters or notices on the walls in a language they can understand explaining how they can protect themselves from COVID-19. Exh. 11, at ¶9.

140. Many detainees report that they do not have access to soap to clean their rooms. Exh. 8, at ¶8. The only handwashing stations available to detainees are in their cells or common restrooms, and not in or near the cafeteria. Exh. 7, at ¶22.p.

141. Detainees are housed in shared rooms and cannot remain 6 feet apart for social distancing within the constraints of detention. Exh. 8, at ¶9. In the legal visitation area, for example, detainees’ chairs are very close to one another, definitely less than 6 feet apart. Exh. 9, at ¶¶13-18.

142. Detainees report that they are forced to remain in close contact with each other when eating together in the shared cafeteria, when in line for the cafeteria and the medical center, and when in their shared bedrooms. *Id.*; Exh. 11, at ¶7. One family estimated that approximately 120 people fit into the cafeteria during mealtime, and the cafeteria fills to capacity as people wait outside in line to be able to eat. Exh. 8, at ¶9.

143. Children at Karnes continue attending school within the detention center, and continue being placed in daycare. *Id.*; Exh. 7, ¶¶22.q; 32.

144. In the legal visitation area, children's toys do not appear to be cleaned or sanitized after used by a child. Exh. 9, at ¶¶13-18. Telephones that are used by detainees in legal visitation rooms are not wiped down between uses. *Id.* GEO guards that check detainees in for their legal visits do not wear gloves when they are handling detainee IDs, pens, or clipboards. *Id.*; Exh. 11, at ¶8.

145. Karnes staff does not follow basic CDC guidelines for preventing the spread of the coronavirus. Exh. 9, at ¶9. While legal visitors now have their temperature taken, and are asked to answer a questionnaire, no other apparent precautions are being taken. *Id.* Staff that process legal visitors and handle materials such as driver's licenses or visitors' badges do not wear gloves or wipe down surfaces regularly accessed by visitors. Exh. 9, at ¶9. The guards shake hands, do not abide by 6 feet of social distancing in line to clock in or clock out, and do not wear gloves or a protective mask. Exh. 8, at ¶10.

146. Detained fathers have been tasked with cleaning high traffic restrooms, tables, doors, and windows but only given gloves and no other protective gear to protect them. Exh. 9, at ¶10; Exh. 11, at ¶7.

147. Poor medical care is a routine complaint by nearly all families. Exh. 7, at ¶9. Multiple families have expressed concerns that their children are not eating and losing significant amounts of weight and that Karnes medical staff fails to take any action, stating simply that it is "normal" for young children to not eat or gain weight. Exh. 9, at ¶¶ 2-3; Exh. 11, at ¶3. Many families similarly report that Karnes' medical staff fail to adequately treat children with vomiting and diarrhea. *Id.* at ¶22. Pregnant detainees have been told by medical staff that they are too busy

to attend to the detainee's needs. Exh. 10, Declaration of Richard Paquiot at ¶ 3. Karnes' medical care is not adequate for basic medical needs such as headaches and the common cold. Exh. 8, at ¶6.

D. All Detainees Should Be Released from ICE Detention.

148. Because risk mitigation is the only known strategy that can protect vulnerable groups from COVID-19, public health experts with experience in immigration detention and correctional settings have recommended the release of vulnerable detainees from custody.

149.

LEGAL FRAMEWORK

I. Violation of Constitutional Rights and the Administrative Procedure Act

150. "Federal courts possess whatever powers are necessary to remedy constitutional violations because they are charged with protecting these rights." *Stone v. City & Cnty. of San Francisco*, 968 F.2d 850, 861 (9th Cir. 1992).

151. As a result, "[w]hen necessary to ensure compliance with a constitutional mandate, courts may enter orders placing limits on a prison's population." *Brown v. Plata*, 563 U.S. 493, 511 (2011).

152. When the government detains or incarcerates a person, it has an affirmative duty to guarantee conditions of reasonable health and safety: "when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being." *DeShaney v. Winnebago County Dept. of Soc. Servs.*, 489 U.S. 189, 199-200 (1989).

153. As a result, the government must provide those in its custody with "food, clothing, shelter, medical care, and reasonable safety." *Id.* at 200.

154. The Supreme Court has found that the Eighth Amendment protects against future harm to inmates, as “it would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.” *Helling v. McKinney*, 509 U.S. 25, 33 (1993).

155. The Eighth Amendment requires that “inmates be furnished with the basic human needs, one of which is ‘reasonable safety.’” *Helling*, 509 U.S. at 33 (quoting *DeShaney*, 489 U.S. at 200).

156. The Supreme Court in *Helling* recognized that the risk of contracting a communicable disease may constitute such an “unsafe, life-threatening condition” that threatens “reasonably safety.” *Id.*

157. These Constitutional protections also apply in the context of immigration detention because immigrant detainees, even those with prior criminal convictions, are civil detainees held pursuant to civil immigration laws. *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

158. Because detained immigrants are civil detainees, they are entitled to rights derived from the Fifth Amendment, and the due process protections derived from Fifth Amendment’s due process protections do not allow punishment at all. *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979) (“Due process requires that a pretrial detainee not be punished.”).

159. Because civil detention is governed by the Fifth Amendment rather than the Eighth Amendment, the “deliberate indifference” standard required to establish a constitutional violation in the latter context does not apply to civil detainees like Petitioners. *Jones v. Blanas*, 393 F.3d 918, 934 (9th Cir. 2004), cert. denied, 546 U.S. 820 (2005).

160. A condition of confinement for a civil immigration detainee violates the Constitution “if it imposes some harm to the detainee that significantly exceeds or is independent

of the inherent discomforts of confinement and is not reasonably related to a legitimate governmental objective or is excessive in relation to the legitimate governmental objective.”

Unknown Parties v. Johnson, No. CV-15-00250-TUC-DCB, 2016 WL 8188563, at *5 (D. Ariz. Nov. 18, 2016), *aff’d sub nom. Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017).

161. The Supreme Court declares “that the Due Process Clause protects individuals against two types of government action.” *United States v. Salerno*, 481 U.S. 739, 746 (1987). Thus, “the touchstone of due process is protection of the individual against arbitrary action of government...whether the fault lies in the denial of fundamental due process fairness [procedural due process],...or in the exercise of power without any reasonable justification in the service of a legitimate government objective [substantive due process]...” *City of Sacramento v. Lewis*, 523 U.S. 833 (1998) (citations and internal quotations omitted). “‘Substantive due process’ prevents the government from engaging in conduct that ‘shocks the conscience,’... or interferes with rights ‘implicit in the concept of ordered liberty.’” *Salerno*, 481 U.S. at 746. (internal citations omitted).

162. When the government has promulgated “[r]egulations with the force and effect of law,” those regulations “supplement the bare bones” of federal statutes and in areas of the law, such that agencies must follow their own “existing valid regulations,” even where government officers have broad discretion, such as in the area of immigration. *United States ex rel. Accardi Shaughnessy*, 347 U.S. 260, 266, 268 (1954) (reversing in immigration case after review of warrant for deportation); *see also Morton v. Ruiz*, 415 U.S. 199, 235 (1974) (“[I]t is incumbent upon agencies to follow their own procedures . . . even where [they] are possibly more rigorous than otherwise would be required.”); *Battle v. FAA*, 393 F.3d 1330, 1336 (D.C. Cir. 2005)

(“*Accardi* has come to stand for the proposition that agencies may not violate their own rules and regulations to the prejudice of others.”).

163. Breaches of *Accardi*’s rule constitute violations of both the Fifth Amendment’s Due Process Clause and the APA. *See also, Rowe v. United States AG*, 545 F. App’x 888, 890 (11th Cir. 013) (Recognizing the *Accardi* doctrine holds that to ensure due process an agency is required to follow its own regulations when exercising discretion and issuing a decision); *Mayers v. United States INS*, 175 F.3d 1289, 1300 (11th Cir. 1999) (Recognizing that a review of statutory questions implicates due process and that *Accardi* found using habeas to ensure that due process and that the “crucial question” is whether the Attorney General’s conducted deprived an individual the rights guaranteed under a statute or regulation.) (internal citations omitted).

164. In *Damus v. Nielsen*, 313 F. Supp. 3d 317 (D.D.C. 2018), he Court explained “that ‘agencies cannot relax or modify regulations that provide the only safeguard individuals have against unlimited agency discretion[.]’” citing *Lopez v. FAA*, 318 F.3d 242, 247 (D.C. Cir. 2003) *as amended* (Feb. 11, 2003).

165. Courts have regularly exercised this authority to remedy to remedy constitutional violations caused by overcrowding. *Duran v. Elrod*, 713 F.2d 292, 297-98 (7th Cir. 1983), cert. denied, 465 U.S. 1108 (1984) (concluding that court did not exceed its authority in directing release of low-bond pretrial detainees as necessary to reach a population cap).

166. In the face of this great threat, social distancing and hygiene measures are Petitioners’ only defense against COVID-19.

167. On March 18, 2019, ICE issued a statement on enforcement during the COVID-19 crisis:

OPERATIONAL

03/18/2020

Updated ICE statement on COVID-19

Statement attributable U.S. Immigration and Customs Enforcement

To ensure the welfare and safety of the general public as well as officers and agents in light of the ongoing COVID-19 pandemic response, U.S. Immigration and Customs Enforcement (ICE) will temporarily adjust its enforcement posture beginning today, March 18, 2020. ICE's highest priorities are to promote life-saving and public safety activities.

ICE Enforcement and Removal Operations (ERO) will focus enforcement on public safety risks and individuals subject to mandatory detention based on criminal grounds. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or utilize alternatives to detention, as appropriate.

Homeland Security Investigations will continue to carry out mission critical criminal investigations and enforcement operations as determined necessary to maintain public safety and national security. Examples include investigations into child exploitation, gangs, narcotics trafficking, human trafficking, human smuggling, and continued participation on the Joint Terrorism Task Force. This work will be conducted based on ability to coordinate and work with prosecutors from the Department of Justice and intake at both the U.S. Marshals Service and Bureau of Prisons.

Consistent with its sensitive locations policy, during the COVID-19 crisis, ICE will not carry out enforcement operations at or near health care facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities, except in the most extraordinary of circumstances. Individuals should not avoid seeking medical care because they fear civil immigration enforcement.

Last Reviewed/Updated: 03/18/2020

<https://www.ice.gov/news/releases/updated-ice-statement-covid-19>.

168. In the statement, ICE states that as a result of the COVID-19 epidemic, “ICE Enforcement and Removal Operations (ERO) will focus enforcement on public safety risks and individuals subject to mandatory detention based on criminal grounds. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or utilize alternatives to detention, as appropriate.” *Id.*

169. In *R.I.L.R. v. Johnson*, this Court held that immigration deterrence is and insufficient basis upon which to detain asylum-seeking families who were plaintiffs in that case. *R.I.L.R. v. Johnson*, 80 F. Supp. 3d 164 (D.D.C. 2015) (citing *Kansas v. Crane*, 534 U.S. 407,

412, 122 S. Ct. 867 (2002) (warning that civil detention may not "become a 'mechanism for retribution or general deterrence' — functions properly those of criminal law, not civil commitment") (quoting *Kansas v. Hendricks*, 521 U.S. 346, 372-74 (1997) (Kennedy, J., concurring) (“[W]hile incapacitation is a goal common to both the criminal and civil systems of confinement retribution and general deterrence are reserved for the criminal system alone.”)).

170. The Court in *R.I.L.R.* based its decision, in part, on *Zadvydas*, which grounded its analysis of immigration detention in principles derived from the wider civil-commitment context. *See* 533 U.S. at 690 (citing *Hendricks*, 521 U.S. 346 at 356 and *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992)).

171. Section 212(d)(5)(A) of the Immigration and Nationality Act permits the Attorney General, at his or her discretion, to “parole” any noncitizen into the United States “temporarily under such conditions as [she or] he may prescribe only on a case-by-case basis for urgent humanitarian reasons or significant public benefit.”

172. 8 C.F.R. § 235.3(b)(1)(iii) vests the Attorney General with the discretion to parole detained aliens with negative credible/reasonable fear findings in expedited removal as required “to meet a medical emergency or is necessary for a legitimate law enforcement objective.”

173. 8 C.F.R. § 235.3(b)(4)(ii) vests the Attorney General with the discretion to parole detainees who have not yet had a credible fear interview in expedited removal as required “to meet a medical emergency or is necessary for a legitimate law enforcement objective.”

174. 8 C.F.R. § 241.4 provides the Secretary of DHS with the discretion to release detainees with final removal orders on orders of supervision based on consideration of factors such as whether the detainee is presently non-violent, whether the detainee is not likely to pose harm to

the community, and whether there are concerns regarding a detainee's mental health. 8 CFR 241.4(e) & (f).”

175.

176. Responding to the current pandemic appropriately by releasing civil immigration detainees who are not a threat to public safety meets all three standards: a medical emergency, a legitimate law enforcement objective and is the very definition of a “significant public benefit.”

177. In addition, the regulations governing ICE's release authority state that individual serious medical conditions are a reason to parole an individual, as “continued detention would not be appropriate” in such cases. 8 C.F.R. § 212.5(b)(1).

A. The Flores Settlement Agreement

178. The United States government is responsible for the care of minors in its custody and, also, is contractually to provide minors in their care special consideration and contractually obligated to process and care for minors consistent with the Flores Settlement Agreement (“FSA”)

179. On January 28, 1997, a class-wide settlement agreement was reached in a case that is presently captioned *Flores v. Sessions*, CV-85-4544 (C.D. Cal.). That agreement unequivocally remains in force today. Individuals may seek redress under the settlement. *See E.O.H.C. v. Sec'y United States Dep't of Homeland Sec.*, No. 19-2927, 2020 U.S. App. LEXIS 4628 at *1 (3d Cir. Feb. 13, 2020) (“This case raises the age-old question: ‘If not now, when?’ Mishnah, Pirkei Avot 1:14. For aliens who are challenging their removal from the United States, the answer is usually ‘later.’ But not always. And not here.”)

180. According to the stipulation of the parties in that settlement agreement, the terms of the FSA are in effect and remain in effect until the 45th day “following Respondents’ publication of final regulations implementing” the FSA itself.

181. On August 23, 2019, the Departments of Homeland Security and Health and Human Services published final regulations in the Federal Register on the “Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children.” Those regulations have been enjoined by Judge Dolly M. Gee, and as a result, the FSA remains in effect.

182. Each federal government Respondent is subject to compliance under the FSA.

183. The FSA applies to “[a]ll minors who are detained in the legal custody of the INS” regardless of whether the child is apprehended unaccompanied or accompanying her parent or family. See *Flores v. Lynch*, 828 F.3d 898, 905-6 (9th Cir. 2016).

184. A “minor” is “any person under the age of eighteen (18) years who is detained in the legal custody of the INS.”

185. The FSA “sets out nationwide policy for the detention, release, and treatment of minors in the custody of the INS[.]”

186. The immigration authorities must treat “all minors in [their] custody with dignity, respect and special concern for their particular vulnerability as minors.”

187. Under the FSA the Respondents have an affirmative obligation to provide for the well-being of immigrant children in the custody of the government. Failing to secure the best interests of minor Petitioners who are detained (as well as all similarly-situated minors in immigration detention) or ensuring their release so that guardians can protect them during a pandemic places their health and their lives at risk. Such action serves no legitimate government interest and is contrary to numerous provisions of the FSA, including but not limited to paragraphs 11, 12A, 14, 24A and 24B and the standards set out in Exhibit 18, FSA.

188. The Flores Settlement Agreement has several provisions which are applicable in the instant matter and which have not been applied to the Petitioners, nor to the remaining asylum-seeking families detained in FRCs, nor the general public.

189. Even in times of a pandemic, the government is obligated to follow the settlement, as the settlement contemplates what is required to protect children in custody, even in extreme instances, as well as has provisions as to the care of minors to protect *others*.

190. The FSA requires that ICE understand and at appropriately, given the fact that children in immigration detention are vulnerable. So are families. The FSA requires *all* decisions on minor's custody *must* be made taking into account the particular vulnerability of children *as well* as to protect *the minor's well being and that of others*. See *id.* at ¶ 11.

191. The FSA requires *safe and sanitary conditions* for children and that they be processed expeditiously. The FSA requires a detention determination *without unnecessary delay* and that the determination be made to *not only* ensure appearance in court, *but to ensure the safety of minors or others*. See *id.* at ¶¶ 12 & 14.

192. Further, if the DHS desires to continue to detain the child due to a concern for safety, they are *obligated to immediately provide a bond hearing before an immigration judge, in every case*. Paragraph 24A. See *id.* at ¶ 24. Further, in the case of detained children, in consideration of bond, *simultaneous release of the detained parent pursuant to 8 C.F.R. 1236.3(2) must be considered*.

CLAIMS FOR RELIEF

Count I

(Violation of Fifth Amendment Right to Due Process--Unlawful Punishment; Freedom from Cruel Treatment and Conditions of Confinement)

193. Petitioners reallege and incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

194. The Fifth Amendment to the U.S. Constitution guarantees that civil detainees, including all immigrant detainees, may not be subjected to punishment. The federal government violates this substantive due process right when it subjects civil detainees to treatment and conditions of confinement that amount to punishment or does not ensure those detainees' safety and health.

195. Respondents' conditions of confinement subject Petitioners to heightened risk of contracting COVID-19, for which there is no vaccine, known treatment, or cure.

196. Respondents are subjecting Petitioners to a substantial risk of serious harm, in violation of Petitioners' rights under the Due Process Clause.

197. As public health experts in correctional medical care and infectious disease agree, families in immigration detention are at grave risk of COVID-19 infection.

198. Accordingly, Respondents are subjecting Petitioners to detention conditions that amount to punishment and that fail to ensure their safety and health.

199. For these reasons, Respondents' ongoing detention of Petitioners violates the Due Process Clause.

Count II

(Violation of the Administrative Procedure Act as to All Respondents)

1. All the foregoing allegations are repeated and re-alleged as though fully set forth herein.

2. Respondents failure to act in a timely manner to protect Petitioners interferes with the rights of Petitioners in an arbitrary and capricious manner and is without justification.

3. The continued refusal to establish and implement policies and procedures designed to prevent the transmission of COVID-19 is contrary to Petitioners' constitutional rights as it violates their substantive and procedural due process rights, as outlined above.

4. By failing to establish and implement policies and procedures to protect to prevent Petitioners from the transmission of COVID-19 in the FRCs, Respondents have enacted a final decision.

5. This decision is constituting final agency action and is reviewable by this Court.

6. When a government agency detains individuals for civil immigration purposes during a pandemic crisis and fails to adhere to the most basis and minimally adequate "arbitrary, capricious, an abuse of discretion, [and] not in accordance with law." 5 U.S.C. § 706(2)(A).

7. Here, by detaining Petitioners without a minimally adequate plan or procedures is arbitrary and capricious and an abuse of discretion. The failures to comply with Respondents' own policies and procedures is not in accordance with law – in violations of the Administrative Procedure Act.

Count III

(Violation of Flores Settlement Agreement—Minor Petitioners Only)

8. Petitioners reallege and incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

9. The Flores Settlement Agreement requires the Respondents to safeguard and protect immigrant children in their custody, including: treating them with care appropriate to their inherent vulnerability as minors; holding minors in facilities that are safe and sanitary consistent with that concern and as laid out in Exhibit 1 to the FSA; releasing minors from

custody “without unnecessary delay” in order to ensure the minors’ safety or that of others; affording them and their parents an immediate bond hearing before an immigration judge “in every case” in which they fail to meet any of these requirements. *See* Exh. 18, FSA at p. 25.

10. Further, the Flores Settlement Agreement requires the government to render custody determinations without unnecessary delay and to consider not only the vulnerability of minors but also the concern or safety of others.

11. Pursuant to Paragraph 24B of the FSA, the minor Petitioners assert that their placement does not comply with the *Flores* standards. Pursuant to Paragraph 36 of the FSA, the 24B claim does not limit the minor Petitioners rights to pursue any other relief to which they may be entitled.

12. Respondents are not in compliance with any of these requirements, have not met their obligations, and have endangered the lives of the children in detention, the families, the surrounding populations and the general public.

13. The conditions in immigration detention for the minor Petitioners , and the continued failure to provide them with appropriate necessary and critical medical care to prevent COVID-19 transmission lacks any justification and violates the rights of minors under the Flores Settlement Agreement.

Count IV

(Writ of Mandamus)

All the foregoing allegations are repeated and re-alleged as though fully set forth herein.

14. As set forth above, Respondents are in violation of the Flores Settlement Agreement, federal statutes and regulations and the U.S. Constitution.

15. These legal obligations for care of individuals held in civil immigration detention create affirmative duties to act, which Respondents have failed to respect.

16. Petitioners accordingly seek a writ of mandamus to require the Respondents to act immediately in accordance with their legal obligations to protect Petitioners and to follow their own parole guidelines and directives.

17. Petitioners are contemporaneously filing a motion for a temporary restraining order.

Count V

(Declaratory Judgment Act)

18. All the foregoing allegations are repeated and re-alleged as though fully set forth herein.

19. The Declaratory Judgment Act, 28 U.S.C. §§ 2201-2202, provides that “[i]n a case of actual controversy within its jurisdiction . . . any court of the United States . . . may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought.” 28 U.S.C. § 2201(a).

20. There is an actual controversy between the parties because Respondents are failing to implement adequate protocols to prevent the transmission of COVID-19 in the FRCs.

21. The Court should exercise its authority under the Declaratory Judgment Act to declare that Respondents have no basis to refuse to implement adequate protocols to prevent the transmission of COVID-19 and should order Respondents to immediately release Petitioners and all detainees to protect them from the dangers of COVID-19 transmission.

PRAYER FOR RELIEF

WHEREFORE, Petitioners respectfully requests this Court to:

1. Assume jurisdiction over this matter;
2. Declare that the Respondents’ conduct constitutes a danger to public health and safety;

3. Order the immediate release of Petitioners and all detainees in the FRCs pending the completion of these proceedings, pursuant to the Court's inherent powers;
4. Immediately release Petitioners and all detainees in the FRCs pending the completion of these proceedings pursuant to the Court's inherent powers;
5. Immediately order Respondents to immediately implement all protocols designed to prevent the transmission of COVID-19 as indicated in the attached expert declarations or protocols of the CDC;
6. Prohibit the placement of new families or other detainees in the FRCs until all protocols designed to prevent the transmission of COVID-19 have been implemented;
7. Declare that Respondents' detention of Petitioners unconstitutional in violation of the Fifth Amendment;
8. Declare that Respondents have violated the Flores Settlement Agreement;
9. Declare that Respondents have violated the Administrative Procedures Act;
10. Award Petitioners their costs and reasonable attorneys' fees pursuant to the Equal Access to Justice Act; and

11. Grant such further relief as the Court deems just and proper.

Dated: March 21, 2020

Respectfully submitted,

By: /s/ Gregory P. Copeland

Gregory P. Copeland (D.D.C. Bar # NY0311)

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Attorneys for Petitioners

***Application for admission pro hac vice forthcoming*

VERIFICATION

I am submitting this verification on behalf of the Petitioners because I am one of the Petitioner's attorneys. I have discussed with the claims with Petitioners' legal team and the events described in this Emergency Petition. On the basis of those discussions, on information and belief, I hereby verify that the factual statements made in the attached Emergency Verified Petition for a Writ Of Mandamus are true and correct to the best of my knowledge.

Dated: March 21, 2020

By: /s/ Gregory P. Copeland
Gregory P. Copeland (D.D.C. Bar # NY0311)

Attorney for Petitioners

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

O.M.G. et al.,

Petitioners,

v.

WOLF et al.,

Respondents.

**DECLARATION OF
GREGORY P. COPELAND**

Case No. 1:20-cv-00786

I, Gregory P. Copeland, being duly sworn, do hereby declare and state as follows:

1. I make this declaration under penalty of perjury pursuant to 28 U.S.C. §1746 in support Petitioners' Emergency Verified Petition for a Writ of Mandamus ("Petition"). I am a Legal Director with Rapid Defense Network (RDN). RDN together with ALDEA-The People's Justice Center and the Refugee and Immigrant Center for Education and Legal Services (RAICES) are counsel for Petitioners.
2. Petitioners are seeking emergent relief from this Court because they are non-citizen parents and their children detained in purported civil immigration family detention and are in conscious shocking risk of exposure to contracting the deadly COVID-19 virus in the midst of a global pandemic by failing to take the mostly minimally precautions to prepare for the all too foreseeable catastrophe in crowded family detention.
3. The following Exhibits are submitted in support of the Petition.
4. Attached hereto as Exhibit 2 is a true and correct copy of the Declaration of Bridget Cambria.
5. Attached hereto as Exhibit 3 is a true and correct copy of the Declaration of M.B.G.
6. Attached hereto as Exhibit 4 is a true and correct copy of the Declaration of Shalyn Fluharty.
7. Attached hereto as Exhibit 5 is a true and correct copy of the Declaration of Allison Herre.

8. Attached hereto as Exhibit 6 is a true and correct copy of the Declaration of Stephanie Alvarez-Jones.
9. Attached hereto as Exhibit 7 is a true and correct copy of the Declaration of Andrea Meza.
10. Attached hereto as Exhibit 8 is a true and correct copy of the Declaration of Julia Valero.
11. Attached hereto as Exhibit 9 is a true and correct copy of the Declaration of Laila Ayub.
12. Attached hereto as Exhibit 10 is a true and correct copy of the Declaration of R.P.
13. Attached hereto as Exhibit 11 is a true and correct copy of the Declaration of T.F.
14. Attached hereto as Exhibit 12 is a true and correct copy of the Declaration of Dr. Ronald Waldman.
15. Attached hereto as Exhibit 13 is a true and correct copy of the Declaration of Dr. Julia DeAun Graves.
16. Attached hereto as Exhibit 14 is a true and correct copy of the Letter to Congress Profs. Allen and Rich.
17. Attached hereto as Exhibit 15 is a true and correct copy of the Declaration of Dr. Jaimie Meyer.
18. Attached hereto as Exhibit 16 is a true and correct copy of the Declaration of O.M.G.
19. Attached hereto as Exhibit 17 is a true and correct copy of the Declaration of C.L.
20. Attached hereto as Exhibit 18 is a true and correct copy of the Flores Settlement Agreement (“FSA”)
21. Attached hereto as Exhibit 19 is a true and correct copy of the Declaration of Dr. Rachel Pearson.

22. Attached hereto as Exhibit 20 is a true and correct copy of the Declaration of Amy Maldonado,
Esq.

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

Dated: March 21, 2020
Brooklyn, New York

/s/ Gregory P. Copeland
Gregory P. Copeland (D.D.C. Bar # NY0311)

DECLARATION OF BRIDGET CAMBRIA, ESQ.

I, Bridget Cambria, declare and say as follows:

1. My name is Bridget Cambria, Esq. and I am an attorney licensed to practice in the State of Pennsylvania since May of 2007. This declaration describes my experiences and observations working with clients detained in an ICE family residential center, including detention practices and conditions and, in particular, issues concerning the detention of parents and children in the Berks Family Residential Center during the COVID-19 pandemic, their concerns about contracting a life-threatening illness in detention and the conditions of detention which threaten the lives of the families in immigration family detention in Pennsylvania.
2. For more than 12 years, I have exclusively practiced immigration law, working with children, families and adults, both in the detained and non-detained settings. In my practice, I have represented immigrants, children and families before Immigration Courts nationwide, the Board of Immigration Appeals, Federal District Courts and the Third Circuit Court of Appeals. I am a graduate of the Roger Williams School of Law, where my studies focused on immigration and public interest law. Prior to law school, on or about 2002, I was employed by the County of Berks as a staff member at the Berks County Residential Center (hereinafter "BCRC," previously and alternatively known as the "Berks County Youth Center", "Berks Family Shelter", or the "Berks Family Detention Center").
3. Currently, I am an attorney with, and the Executive Director of, Aldea – The People's Justice Center ("Aldea"), a non-profit located in Reading, Pennsylvania in the County of Berks. Our organization, Aldea, offers universal representation to families detained at the Berks County Residential Center in Leesport, Pennsylvania. In the last five years, we have represented more than one thousand parents and children who have been detained in family detention in the BCRC.

4. In the course of employment, I have regular occasion to observe, and therefore am familiar with, the policies and practices of United States Immigration and Customs Enforcement (“ICE”) toward the detention, release, and treatment of children and parents in family detention generally and the Berks County Residential Center. I have also had the opportunity to observe detention practices and detention conditions for families detained by ICE in Pennsylvania.
5. Aldea maintains a near daily presence on the ground at the BCRC providing pro bono legal services to detained families at no cost to ensure that all detained families and children have access to legal services in immigration matters, which often times is a matter of life and death. Families detained at the BCRC are seeking protection from persecution and torture and are actively pursuing asylum, withholding of removal and protection under the United Nations Convention Against Torture. Although the majority of families detained in Berks are from Mexico, Guatemala, Honduras and El Salvador, families in the BCRC come from all over the world. Other countries currently represented in the detained population at Berks include also families from Haiti and India.
6. Prior to arriving at Berks, the vast majority of families are first detained in a “*hielera*” (“icebox”) prior to arriving at Berks. Our clients frequently report they were crammed into a large, cold cell for multiple days without access to hot meals, showers, toiletries, medical care, and beds while in CBP custody. Following this time in unsanitary conditions in CBP the families are transported to airports and flown to the BCRC. Often we observe families and children arriving to the facility ill due to the poor conditions in CBP custody, and often children and families fall ill shortly after arriving at the detention center as a result of the same.

Detention Practices at the Berks County Residential Center

7. I have provided legal services to the BCRC for more than five years and am a Flores Consultant, meaning that I participate in discussions concerning the legal rights of detained

minors pursuant to the Flores Settlement Agreement (FSA). It is undoubtable that the current pandemic prevents appropriate care of minors in ICE custody as required under the FSA which requires that custody determinations must be made while taking into account the particular vulnerability of children as well as to protect the minor's *well being and that of others*. See Paragraph 11. The FSA requires *safe* and sanitary conditions for children and that they be processed expeditiously. The FSA requires a detention determination *without unnecessary delay* and that the determination be made to not only ensure appearance in court, but to *ensure the safety of minors or others*. See Paragraph 12 and 14. Further, if for some reason, such as danger, the DHS desires to continue to detain the child, they are obligated to immediately provide a bond hearing before an immigration judge, *in every case*. Paragraph 24A. Further, in the case of detained children, in consideration of bond, simultaneous release of the detained parent pursuant to 8 C.F.R. 1236.3(2) *must* be considered.

8. I have also had an opportunity to tour the BCRC facility in my capacity as a Flores monitor. Our staff continue to provide services during the COVID-19 outbreak as we are obligated by the EOIR to provide legal representation in Immigration Courts that remain open. Detained Immigration Courts have not shuttered during the pandemic, therefore our clients, detention centers, and our employees remain at risk.
9. The BCRC detains mothers, fathers and children. The BCRC detains children of all ages, as young as an 11-day-old newborn through children aged 17 years of age. The current population of Berks consists of children as young as 6 months old to children who are teenagers. The BCRC can detain up to 96 persons at one time. As of this writing, we can estimate that about 50 mothers, fathers and children are detained at the BCRC, a facility that consists of one building where the detainees are in close quarters. The placement determination of families in the BCRC, rather than placement in liberty, is made by ICE. The majority of families apprehended by the Department of Homeland Security ("DHS") are

not subject to confinement. By and large, families subject to removal from the United States are subject to alternatives to detention. Those in family detention are the exception and not the rule.

10. Family detention by the DHS occurs only in the BCRC in Leesport, Pennsylvania, the South Texas Family Residential Center in Dilley, Texas and the Karnes County Residential Center, in Karnes, Texas. A family cannot be detained in any other facility in the United States. For that reason, families are transported from every part of the United States into the family detention centers in Texas and Pennsylvania. We receive families from the Southern Border, from interior apprehensions by ICE throughout the United States and apprehensions at the Northern Border.
11. Not a single family in the Berks County Residential Center has a criminal record. Every family in the BCRC is an asylum seeker, with a pending proceeding with the Asylum Office or the Executive Office for Immigration Review. Every family is considered a “civil detainee.” Every detained family would be subject to the same civil immigration proceeding whether in detention or outside of detention.
12. Routinely, detained families are released from the BCRC by ICE and placed with their families, friends and sponsors who reside in the United States without necessary intervention by a Judge or the requirement of payment of a monetary bond given the particular vulnerability of children, to ensure proper care of children outside of a detention environment, and because asylum-seeking detainees can provide a fixed address wherein the family will reside while abiding by alternatives to detention, including electronic monitoring, phone monitoring, in person ICE supervision appointments and/or participation in an intensive supervision appearance program.

13. Family detention is the secure detention of parents and children. The BCRC is a secure care facility. It is a secure facility in several ways, however, most simply, no parent or child is free to leave the facility.

14. The BCRC is a facility that consists of a single building. It is owned and operated by the County of Berks. The facility is staffed with more than 60 employees. Further, the facility has a medical clinic, which is staffed with medical personnel of an unknown number. The building is also occupied by ICE who operates a Field Office from within the same building as the family detention center. The ICE offices are fully staffed with ICE personnel of an unknown number. It includes the Enforcement and Removal Officers assigned to the BCRC itself, as well as ICE personnel who operate in the field throughout the surrounding region, administrative personnel for the family detention center as well as the ICE office itself. The ICE offices also possess holding areas for local ICE arrests, including those persons arrested by ICE in the Berks County area as well as those ICE detainees released from local jails pursuant to ICE detainers. An unknown number of detainees are processed at the BCRC over and above the families detained at the center. There is a constant ebb and flow of officers, personnel, families, children and detainees that come and go from the BCRC.

15. Families in the BCRC are held in very close spaces with lots of other detainees, employees of the facility and ICE personnel. The detainees sleep in rooms with six beds to a room. Each of the currently detained families are in overcrowded bedroom spaces. The detainees state that less than one half, of one meter of space divides the beds in their room. Detained families are advised of this in their Resident Handbook. *See attached excerpts from the Resident Handbook.* “At the Center, you will be living in close proximity with other families, so personal hygiene is essential. You are expected to bathe regularly and keep your hair clean.” *[See Handbook page 13]* Further, “due to the communal nature of the Center ... children from different families may room together, and non-related adults room together.” *[See Handbook Page 9]* Detained families often are required to use the same items, spaces,

and toys which are located throughout the detention center. “Residents are expected to share common equipment such as telephones, televisions, tables, recreational games and other equipment.” *[See Handbook Page 9]*. The more than 50 current detainees are limited to two floors of a single building, where they share limited common areas, shared sleeping quarters, shared bathrooms, and a very cramped dining area.

16. Throughout the day, detained parents and children are mandated to congregate together, including three census periods, three lunch periods and times when free movement is prohibited. At no point is a family permitted to leave the building into the recreation area, except where given permission and at no point may a family leave the facility of their own choosing without being under the threat of federal criminal arrest.
17. Census requires detainees to report to the bedroom floor courtesy desk as a family to check in from 6:30am TO 7:30am 3:00pm TO 4:00pm 7:30pm TO 8:00pm. Failure to comply results in discipline. *[See Handbook page 15]*.
18. Meals are provided in a single dining room three times a day, for both detained families and employees of the Berks facility. The families currently report more than 60 people are in the dining room during meal periods. Detained families, including small children, are required to be present in the dining room from: 7:30am to 8:00am 12:00pm to 1:00pm 5:30pm to 6:30pm. *[See Handbook Page 17.]*
19. The BCRC has a medical unit which is operated by Immigration Health Services Corps. There is no pediatrician nor gynecologist. A doctor is not present in the facility at all times, but comes and goes from the facility. All medical decisions for parents and children are made by the medical unit, including diagnosis, treatment, over-the-counter medication, and whether a parent or child should receive a test or visit a hospital.

20. Detained families are not allowed free movement throughout the BCRC or in recreation at various times, including after 8PM, and during all eating periods. Estimated times when detained families are permitted in outside recreation areas are 8:30AM to 11:30AM, 1:30PM to 4:30PM, and 6:30PM until the sun begins to set, however, they are not permitted outside without a guard escort or observation. At 8:00PM each day, all detained families are restricted to the second floor and no longer permitted even supervised free movement.
21. Children are to be in the company of their parents at all times.
22. In Family Residential Centers, parents are not responsible for determinations as to the care of their children. Parents cannot determine when their children wake up, what they eat or if they need to go to a hospital. Parental decisions are made for children, by the facility procedures, the guards within the facility and by ICE themselves. Children are told when they can and cannot play, when they can or cannot be outside, when they can eat and what they eat, and what happens when they misbehave – by the facility and not their parents. Medical decisions are not made by parents, either. Those decisions are made by ICE medical personnel or County facility staff.
23. Finally, at the BCRC, few employees speak Spanish. If a detainee has a problem, they must make a language service request, a guard must take them to a telephone to connect with an interpreter by phone, and an interpreter must be available. This arrangement does not permit adequate care of children, especially during emergencies. In a pandemic, the lack of in person interpreters in facilities that detain immigrants threatens the lives of the parents and children they detain. There is no way to communicate an emergency to a staff member quickly if neither the detainee nor the staff understands what is being said. This is unacceptable in an environment with children during the COVID-19 outbreak.

Detention Conditions at the BCRC During the COVID-19 Pandemic

24. I have had the opportunity to interview the detainees about their concerns and worries with the outbreak of the COVID-19 pandemic. The families are scared.
25. It is impossible for detained parents and children at the BCRC to practice social distancing—remaining 6 feet from others— as has been recommended to combat the COVID-19 pandemic. Based upon my observations at Berks, it would be impossible for detained individuals to create the distance between themselves and other detainees necessary to protect themselves. Detainees are forced to sleep in close quarters with others, share crowded bathrooms, and are forced to congregate in small communal areas. There are no more than two floors of permitted movement space for every single detainee limited to a handful of small rooms.
26. Clients of Aldea are very concerned that they will be exposed to COVID-19 and that they lack access to appropriate testing or medical treatment services while in detention. This is exacerbated by the fact that they cannot make medical decisions for themselves or their children. Without exception, each family interviewed by Aldea has reported that their children are currently ill, or were recently ill. Without exception, the families advised knowing about the outbreak only through news reports and are upset that the facility has not advised them the reality of what is happening on the outside of detention.
27. Detainees report that children and parents were not educated about the COVID-19 outbreak. They were not advised of different processes or procedures employed by the facility to prevent spread. They report a sign was posted saying “Wash your hands” in Spanish, but that other posters were in the English language and they are unable to read them. One detained family reported they were told to “cough in their elbow” and that was all.

28. Many families report having inadequate access to soap and hand sanitizer at the facility.

Families report that hand sanitizer is available only for the staff and not for the detainees. I can report that there is hand sanitizer in the lobby of the facility, which is inaccessible to the detainees, as well as the legal visit room. I have instructed the detainees to use the hand sanitizer within the legal area. The families report it is not available elsewhere for them to use freely. The families report at times a lack of access to hand and body soap. In some instances, they reported no soap in bathrooms and broken dispensers which have not been fixed.

29. Detainees do not have gloves or masks. Upon observation, staff was not wearing masks.

Residents reported that the staff did use gloves when treating the detained families.

Detainees only have access to gloves when they clean. They are paid \$1 dollar a day to participate in a voluntary work program which, in part, cleans the facility. Upon observation there is no outside cleaning service. Cleaning is conducted by the families and the shelter care counselors of the BCRC.

30. Families expressed great concern about the health of their children. They express that they see staff of the facility spray cleaning product throughout a room, but do not wipe anything.

They state they see the staff spray cleaning product directly on top of the children's toys, that both ill and well children play with toys, and parents fear that children often touch many things and put toys in their mouth, spreading germs.

31. The detained families reported that children, parents and staff within the facility have shown signs of illness. Residents have noticed that some staff have disappeared from work, and the families are concerned that the staff is exhibiting symptoms. The detained families are exceptionally worried about new families being introduced into the BCRC without adequate screening, since they report that families are arriving sick into the center.

32. Families report that children who show symptoms like constant cough, fever, sore throat, lethargy, congestion, difficulty breathing or sleeping, lack of appetite often go untreated. When treated, they are only provided Tylenol and it takes much time to receive actual medicine. Often, families report they are told the problem is allergies and that is all. This is true even in the time of the COVID-19 pandemic. Two days prior to this writing, Aldea staff requested “cough syrup” for a two-year-old boy who has a persistent cough and upon appearance was visibly ill. We requested the medicine when asked to inquire by client, as is often the case when children are ill for a prolonged time without treatment. Upon request to we were asked “What is cough syrup?” Then upon speaking with a caseworker to continue to ask for cough medicine, we were advised that we could not ask him that it was medical’s decision, and when we asked to fill out a resident request form for cough medicine, were told that that such a request didn’t exist, despite such requests being available pursuant to the detainee handbook. *[See Handbook Page 8]*
33. Families often face an impossible wall to receiving medical care in detention, which rings the alarm to legal service providers as to what will happen when the pandemic hits the detained population. It will result in a threat to the lives of men, women, parents and children.
34. As of this writing, we are unaware of any parent, child or employee at the BCRC who has been tested for COVID-19, this is despite the fact that the families and children do have cold and flu-like illnesses.
35. The facility can, and has, isolated families at different times. During medical isolation in detention, a parent is isolated with their children. They are isolated together even when only one of the members of the family unit is ill. There is no physical capability to medically quarantine everyone.

36. The facility does not have 24/7 doctors on site and cannot treat emergencies. A hospital is closely located to the detention facility, however, an outbreak of COVID-19 with parents and children at Berks will overwhelm the small local hospital that is currently dealing with the population of Berks County and the city of Reading, PA. Further, and undoubtedly, should one person at the BCRC contract the COVID-19 virus, every person in the BCRC may be affected given the communal nature of family detention.

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

Executed this 20th of March, 2020 in Reading, Pennsylvania.

A handwritten signature in black ink, appearing to read "Bridget Cambria". The signature is written in a cursive style with a large initial "B" and "C".

Bridget Cambria, Esq.



Berks Family Residential Center

Resident Handbook

**1040 Berks Road
Leesport, PA 19533
610.396.0310**

- For students- follow classroom rules that are established by the teachers and the Center staff;
- Promptly report broken items or damaged property to staff;
- Alert staff immediately of any problems or concerns;
- Ask staff if you do not understand or remember Center rules;
- Abide by the room visitation policy. See the section concerning bedrooms for more information;
- Do not borrow or trade clothing, hygiene products, jewelry or make-up;
- Do not deface or otherwise damage Center property;
- Comply with the dress code found in this handbook;
- Do not use tobacco products, alcohol or gum;
- Do not waste food;
- Do not use profanity.

Failure to follow the above rules may result in the initiation of disciplinary proceedings. Serious and/or continuous infractions may lead to a review of your continued suitability for placement in this residential setting. See the section on disciplinary procedures for more information. Residents who act in an aggressive manner and/or attempt to cause harm to themselves or others, may be passively restrained under the Center restrictive procedure policy to protect themselves and others.

RESIDENT REQUESTS

Generally, residents can have questions answered and obtain services merely by speaking to staff. For those who would rather request information formally, the official method is by completing a Resident Request form. These forms are available at the Resident Information Center. Please complete all the information requested on the forms. You may obtain assistance from another resident or staff member in preparing your request form. Completed forms are to be placed in the mailbox labeled "Requests" located at the Resident Information Center. These forms are collected each business day and routed to a caseworker for resolution. This procedure is not to be used for submitting formal grievances. See the section on grievance procedures for more information.

CONTACTING IMMIGRATION

ICE staff are assigned to your immigration case and conduct announced and unannounced (not scheduled) visits to the Center. The purpose of these visits is to speak to residents about their immigration concerns and observe living conditions. You may visit with ICE during their announced visits and also submit written questions, requests or concerns to them by completing an ICE communication form. These forms are available at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "ICE. These forms are collected each business day and routed to ICE without

being read or altered. You may obtain assistance from another resident or staff member in preparing your request form. The ICE staff receiving your request form will respond to you. ICE officers are the only staff who can answer immigration related questions. See the posted ICE visit schedule at the Resident Information Center. The county staff, in blue shirts and tan pants/shorts you interact with at the Center cannot answer any immigration related questions.

CASEWORKERS

Each family admitted to the Center is assigned a specific caseworker, although questions may be directed to any of the caseworkers as needed. These caseworkers assist residents with questions regarding rights, rules, responsibilities, programing and services, housing and education, property issues, access phone numbers and addresses of family and friends, treatment referrals and other issues that arise while living at the Center. Residents may contact the caseworkers in their office on the activity floor during free movement and through the use of a Resident Request form. These forms are located at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "Requests". Signup sheets for hair care services, legal aid assistance and phone calling cards among other items are located outside of the caseworkers' office.

LIVING ARRANGEMENTS

Residents are expected to share common equipment such as telephones, televisions, tables, recreational games and other equipment. Quiet hours are from 10:30am to 6:30am on weekdays (Sunday night through Thursday night) and at 12:00 midnight to 6:30am on weekends (Friday and Saturday night) and holidays. During quiet hours residents are expected to refrain from activities which would disturb the sleep of others.

BEDROOMS

Children 12 years and under will be assigned a bedroom with their parent. Children 13 years and over will be assigned a bedroom with other children of the same gender and like age. Each resident is provided with their own bed. Residents should make their beds and straighten up their immediate area each morning. When not in use, beds should remain made. Beds are not to be moved. Due to the communal nature of the Center, where children from different families may room together, and non-related adults room together, residents must abide by the following room visitation policies to ensure the privacy and safety of all residents: Anytime an unrelated child is present in a bedroom, adult residents must have staff supervision while in that bedroom. Children may enter their parent's bedroom only in the company of their parents. As there are many areas in the Center to relax with other residents for conversation, adults are not allowed to congregate in bedrooms. Residents are permitted to decorate their rooms with personal items, so long as the decorations do not present a health or safety hazard, do not peel paint off the walls or otherwise deface Center property. No items are allowed to cover

the light fixture, doors or windows. Items are not to be hung from vents or beds. Due to the communal nature of the Center, residents are encouraged to only change their clothes in the shower rooms or in their bathroom. Approved property will be stored inside assigned bedroom closets. See the section on allowed personal property for more information. Closets shall be kept organized. No open food or drinks are allowed to be stored in bedrooms. Unopened commissary purchases may be stored in bedrooms provided they are kept in a closed bin to discourage pests. All hygiene items must be stored hygiene boxes and kept in assigned bedroom closets. Toys are allowed in bedrooms during free movement hours. After free movement, all toys must be taken back to the common areas so that they can be sanitized for the following day. See the section on free movement for more information.

CHILDREN'S BEDTIMES

Children's bedtimes were set to promote a routine for the Center children and to allow for their restful attendance in class. The general bedtime for children 4 years and younger is 8:30pm Sunday through Thursday. The general bedtime for children 5 years to 18 years is 9:00pm Sunday through Thursday. Lights are turned out 15 minutes after these bedtimes. There are no general bedtimes set for children on Friday and Saturdays. Parents are encouraged to continue (or develop) their children's bedtime routines while at the Center.

OVERNIGHT CHECKS

State regulations require staff to conduct room checks at a minimum of every fifteen minutes during each overnight to ensure resident safety. During these checks staff is required to shine a flashlight into your room; the checks will be done with as little disruption as possible.

FREE MOVEMENT

Barring temporary restrictions due to medical or security reasons, free movement hours are from 8:00am to 8:00pm each day. During this time adult residents are allowed to move freely throughout all programming areas of the Center without first asking staff permission or notifying staff where they are going. Children age 10 and older may participate in free movement, when issued a pass by their parent. See the section on free movement passes for more information. Children over 10 who do not currently have a pass and all children under 10 years old are expected to be under the direct supervision of their parent at all times when not in school or participating in an organized activity. Outside of free movement hours, residents are expected to remain on the bedroom floor. This floor has resident bedrooms, dayroom, law library, telephone room, medical department, bathrooms and shower rooms; all of which may be accessed freely 24 hours a day.

These linens will be exchanged for clean linens once a week, or more frequently as needed. Speak with staff should an occasion arise when you need clean linens outside the normal exchange day.

LAUNDRY

Laundry services are available 7 days a week. Each family is scheduled to wash their laundry on an assigned day. The laundry schedule is posted near the laundry room door on the bedroom floor. In the event clothing become soiled between scheduled laundry times, ask staff for additional clothing and/or to be given additional time to wash laundry. See staff at the bedroom floor courtesy desk for machine soap and machine use instructions. Report any machine issues to staff at the bedroom floor courtesy desk.

PERSONAL HYGIENE

At the Center, you will be living in close proximity with other families, so personal hygiene is essential. You are expected to bathe regularly and keep your hair clean. Upon arrival to the Center each resident was issued hygiene products. These items may be replaced as needed by submitting a Resident Request form. These forms are located at the Resident Information Center. Completed forms are to be placed in the mailbox labeled "Requests". You are also allowed to purchase hygiene items from the Center commissary. Feminine hygiene items are available in the female shower room on the bedroom floor. Residents have free access to showers during free movement hours, 7 days a week. Should you need to shower at other than free movement times, speak to staff. The shower rooms are labeled according to gender (male and female). Children 9 years and older will shower according to their gender. Should your child need assistance and is older than 9, see staff for accommodations. Children 8 years and younger will shower only under the direct supervision of their parent so as to not disturb other residents using the shower room. Adults may wear their own make-up. All make-up must fit in a hygiene box or it will need to be placed in storage. Razors are available at any time by speaking with staff at the bedroom floor courtesy desk. Residents will exchange their Center identification for a razor and return it to the courtesy desk staff immediately after use. Nail clippers and tweezers are available through the Center commissary.

ALLOWABLE PERSONAL PROPERTY

While at the Center, you are permitted to retain in your bedroom:

- 10 sets of clothes per resident as described above;
- Personal hygiene items;
- Legal documents, legal papers and legal Information;
- Photos;
- Medical prostheses, (i.e. eyeglasses, dentures, etc.);

The outdoor evacuation location is next to the resident soccer field. Please familiarize yourself with the diagram posted at the recreation door which shows the location of the outdoor evacuation location. There are exit diagrams posted around the Center which show the location of all emergency exits. Study these diagrams carefully and become familiar with their locations. Should an emergency occur and you are near a fire exit, do not wait for staff – go down the fire exit to the outdoor evacuation location and wait for staff to arrive. Per local, state and federal laws, the Center is required to perform evacuation drills. The Center performs several drills each month, at varied times of the day and night. These drills are not designed to inconvenience residents, but rather to comply with regulations and ensure resident and staff safety in the case of an actual emergency. Parents should advise and discuss these drills with their children.

RESIDENT CENSUS

At this Center, resident accountability is done through residents reporting for censuses 3 times during each 24 hour period. Census times are:

6:30am TO 7:30am

3:00pm TO 4:00pm

7:30pm TO 8:00pm

Residents will report to the bedroom floor courtesy desk as family units during the times listed above. If residents are at an appointment near the close of the census time, the staff supervising the appointment will report the resident's location. Residents who do not check in properly during census will be counseled regarding the requirement.

THE CENTER LAYOUT

The Center is comprised of two floors and an outdoor campus. The first floor, where you first entered the Center is the activity (A) floor and the second floor is the bedroom (B) floor. The outdoor campus is outlined by a post and rail fence.

Activity Floor (A Floor):

- Center Administration
- Visitation
- Court
- Library
- Internet Café
- Children Education
- Chapel
- Caseworkers' Office
- Supervisors' Office
- Adult Education
- Phone Room
- Indoor Recreation Room
- Resident Fitness Room
- Toddler Room
- Art and Activity Rooms
- Movie Room
- Additional Laundry (use with supervisor approval)
- Additional Showers (use with supervisor approval)
- Day Room
- Game Closet

Bedroom Floor (B Floor):

- Bedrooms
- Phone Room (open 24/7)
- Law Library (open 24/7)
- Day Room
- Game Closet
- Table Games
- Dining Room
- Medical Clinic
- Showers
- Laundry
- Kitchenette

MEALS

All menus are designed to be nutritionally balanced and are approved by a certified dietician. Residents are provided 3 meals each day in the dining room, located on the bedroom floor:

Breakfast 6:30am -8:00am

Lunch 12:00pm -1:00pm

Dinner 5:30 pm – 6:30 pm

Seating in the dining room is not assigned. Residents may sit wherever they desire for each meal. High chairs and booster seats are available in the dining room. Small children are expected to be seated during meals to encourage sound eating habits.

Residents are required to be present in the dining room from:

7:30am to 8:00am

12:00pm to 1:00pm

5:30pm to 6:30pm

Utensils and trays used in the dining room are not disposable. At the end of each meal, residents are required to clear their family's immediate area and return all utensils and trays to be cleaned. Residents are allowed unlimited trips to the self-service bars in the dining room, and it is your responsibly to eat what you take, to reduce food waste. All food or drink must be consumed during the meal – no food or drink may be taken from the dining room.

KITCHENETTES

Fruit, snacks and drinks are available 24 hours a day at the activity and bedroom floor kitchenettes. Residents are not allowed to take more food or drinks from the kitchenettes than they will consume at one sitting. This food is replenished several times a day so there is no need to hoard kitchenette food.

SPECIAL DIETS

Therapeutic/medical diets shall be prepared and provided according to the orders of the Center medical department physician. Religious diets shall be prepared and provided for residents whose religious beliefs require the adherence to religious dietary laws.

Residents are required to meet with the Center Chaplain for religious diet approval. See the section on the Chaplain for more information.

SWORN STATEMENT OF M.B.G.

I, M.B.G., hereby swear and attest, under the penalties of perjury, that the following is true and correct to the best of my knowledge:

1. My name is M.B.G. I arrived at the Berks County Detention Center on March 14, 2020 with my wife M.E.F. and my child A.B.E.
2. When we arrived, we were briefly checked in the medical center. They only took our temperatures to see if we had a fever. We had bloodwork done to see if we had any sickness. I did not fully understand what they were doing to us because I do not understand English. Two days later my arm was inflamed and they took me to the hospital for.
3. The next day after we arrived, they told us that we have to wash our hands and to cough and sneeze into the inside of our elbow.
4. I was separated from my family and we are placed in different housing. I am in a room with three other men. One of them has shown signs that he might be sick. He started coughing and I am afraid that I may get sick as well. We are in a small room and in close proximity of each other. There is nowhere in the center where we can keep a reasonable amount of distance from each other.
5. From what I have seen the Berks detention center is not a sanitary place. The workers do not clean anything. The only thing they do is spray a liquid on surfaces. They do not wipe down tables, door knobs or any sort of surface. They quickly and lightly spray the top of things and then go away.
6. What worries me the most is that the workers do not clean the toys the children play with. Their immune system is still not fully developed and are most at risk. I worry when I see my son play with the toys because I see other children who are obviously sick play with them. I am afraid that the children will spread any illnesses they may have.
7. There are only three places where soap is available. There is one soap dispenser in the cafeteria, one outside the TV room, and one outside the teen playroom. We do not have soap in the room or in our bathrooms. I tried to request soap to a staff member but they did not do anything. I do not know if they do not understand me or they do not want to replace the soap. There has not been any soap in the bathrooms since I arrived to Berks on Saturday March 14, 2020. When we use the bathrooms we are only able to rinse our hands with water.
8. Many of us detained at Berks are afraid because they are not telling us anything about the Corona Virus, they only told us to wash our hands and cough on our elbows. I am frightened because we heard about the virus in Mexico before we were brought to

Berks. The only information we have gotten is from the News on TV and that is in English. We try to read the subtitles but we do not fully understand what is being said.

9. I have noticed that the staff members are keeping their distance from us. They stand as far as they can when they are supervising us. When someone is coughing or looks sick, the staff members just tell them to cough in their elbow and to wash their hands.
10. They have not put any notices or flyers letting us know about the Corona Virus. If they did, we do not know because everything is in English and we do not understand what they posters say.
11. I am afraid that we will catch this Virus because Berks keeps bringing in new people all the time. Every new person has been through the airports and I think they may be infected. Since I do not know anything about the Virus and they have not explained anything to us, I fear that we could get sick at any time.
12. None of the Berks staff speak Spanish and we cannot communicate with anyone. I believe that they should have someone who speaks Spanish explain to us what is going on.

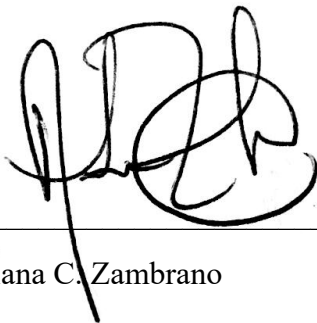
This statement was prepared with me in my native language of Spanish. I understood and agreed with the contents of this statement before signing.

M.B.G. Signature

M.B.G.

3/19/20

I, Adriana C. Zambrano, swear and affirm that I am fluent in both English and Spanish and that the above statement from Mardoqueo Bonilla Garcia is a true and correct translation to the best of my ability.



Adriana C. Zambrano

03/19/2020

DECLARATION OF SHALYN FLUHARTY

I, Shalyn Fluharty, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am an attorney licensed and admitted in the State of California. I am the Director of the Dilley Pro Bono Project (“DPBP”), a volunteer-based project that provides free legal services to asylum-seeking families who are detained at the South Texas Family Residential Center (“STFRC”) in Dilley, Texas. I have served in this role since December 2016.
2. Immigration and Customs Enforcement (“ICE”) has capacity to detain up to 2,400 women and children at STFRC at any given time. The facility is operated by CoreCivic, a private prison company contracted by ICE. Medical services at STFRC are provided by the ICE Health Service Corps.
3. DPBP has maintained a daily on-site presence at STFRC since December 2014, when the facility opened. On March 18, 2020, DPBP ceased in-person visitation with clients in response to the COVID-19 pandemic.
4. Families detained at STFRC seek protection from persecution in the form of asylum. Although the majority of families detained in Dilley are from El Salvador, Guatemala, and Honduras, families detained in Dilley come from all over the world and transit numerous countries in route to the United States. For example, in March 2020, DPBP provided legal services to families from Uzbekistan, India, Romania, Turkey, Haiti, and Brazil, to name a few.
5. Most families are detained at a Customs and Border Patrol (“CBP”) processing center before being transported to Dilley in a bus with many other families. Our clients frequently report they were crammed into a large, cold cell for multiple days without access to hot meals, showers, toiletries, medical care, and beds while in CBP custody.
6. Social distancing—keeping a distance of 6 feet from others—is impossible for families who wish to protect themselves from COVID-19 while detained at STFRC. The facility is comprised of numerous trailers which are enclosed by a perimeter that keeps families from leaving. Detainees are surrounded by hundreds of other detainees at any given time and required to share bedrooms, the bathroom, and numerous communal spaces.
7. ICE and CoreCivic limit the movement of DPBP staff and volunteers at STFRC to four specific locations. The legal visitation trailer is a large trailer just beyond STFRC’s security entrance. It has capacity to hold 135 people at any given time. The trailer has one large common room where approximately 90 people receive Know Your Rights presentations and wait for an appointment with a lawyer at any given time. The legal visitation trailer also houses 14 individual rooms that are used for legal and social visitation with detained families. In order to seek legal services – whether through in-person visitation or telephonically – a detainee must

go to the legal visitation trailer where there are numerous other detainees waiting to speak with counsel most, if not all, of the time. Although there are telephones located in each housing unit, these phones are not free and phone calls are recorded and not confidential.

8. The “court” building is a large trailer with numerous rooms, including five courtrooms that are used for immigration court proceedings and meetings hosted by ICE. The court trailer also contains smaller rooms used for consular visitation and asylum interviews, and two large waiting rooms where 20 or more families are required to wait side by side for their appointments, interviews, and court hearings. Meetings and appointments that occur in the court building are mandatory, not optional. Although perhaps an individual could choose to not go to their asylum interview or court hearing, this would ultimately indicate they were abandoning their request for asylum, and place them at risk of removal. When a court docket or asylum interviews are scheduled, the Executive Office of Immigration Review and asylum office schedule numerous families at the same time. In other words, in order to attend a court hearing or interview, a family is required to be close to a high volume of other families who are simultaneously scheduled to appear.
9. The “asylum” building is a trailer with numerous individual meeting rooms and a lobby that holds approximately 20 people at a time. Families who are scheduled for credible fear interviews with the asylum office are scheduled in groups, and wait in the lobby together, before being called to their interview.
10. “Building 100” is a trailer used by ICE for meetings with large groups of families, and by DPBP for group legal presentations. Building 100 has capacity to hold approximately 45 people at a time. The space is not large, and families who attend meetings in building 100 are typically required to sit approximately six inches away from other individuals who attend the meeting.
11. Although DPBP movement is limited to the four locations detailed above, I was provided a tour of STFRC by ICE in 2017. During the tour I asked questions, and ICE provided a general explanation of facility operations. The tour began in the “intake” trailer. During intake at STFRC, the personal possessions of arriving families are inventoried and stored. Families are provided with uniforms, processed by ICE officials, and given a brief medical screening. During intake – which can last for hours – families wait their turn in line surrounded by numerous other families.
12. Families are assigned to a “neighborhood” and room at intake, where they are housed. A neighborhood is comprised of multiple trailers that are connected by walkways and car ports. Most dormitories contain six bunkbeds (12 beds) that are separated from one another by a few feet. The dormitories do not have a bathroom. Rather, families share a bathroom with many others who sleep in different rooms within their neighborhood. Neighborhoods also have a community room, where detainees gather and have meetings required by CoreCivic.

13. STFRC maintains numerous common spaces, including: (1) a dining hall that holds hundreds of people, (2) a school, divided by multiple classrooms that hold approximately 20 children each, (3) a large gymnasium that is used for group exercise classes and as a waiting room for medical appointments, (4) outdoor playgrounds and spaces where groups of children and families congregate, (5) a large auditorium that holds approximately 200 people, (6) a library, and (7) a small building used to dispense medication to detainees who wait in line at designated times each day.
14. Mothers currently report that detainees are crowded in lines in the dining room, and that there are no efforts to keep individuals from touching or breathing on the food. These reports are consistent with what I personally observed during my tour of STFRC. Mothers have also informed DPBP staff that as of March 20, 2020, the school and daycare at the detention facility continue to operate.
15. During my tour of STFRC I was not permitted to see the medical units. DPBP is generally prohibited from having direct contact with medical staff at the facility.
16. Based upon my observations at STFRC, it would be impossible for detained individuals to create distance between themselves and other detainees. Detainees are required to share rooms and the bathroom and must wait in large communal areas in order to receive access to legal services, medical care, education, and to participate in their legal proceedings.
17. Many DPBP clients are concerned they will be exposed to COVID-19 and not have access to adequate testing or treatment at STFRC. Detained families have access to television at STFRC, and have learned about the outbreak - and its risks and symptoms - by watching the news. To date, DPBP staff is not aware of any formal education provided to families detained at STFRC regarding COVID-19 and precautions for limiting its transmission.
18. Many families report having inadequate access to soap and hand sanitizer at the facility. On March 17, 2020, one mother noted that she had not been able to find soap all morning, and that that there was no soap available to her until at least 1:30 in the afternoon. Another mother informed DPBP staff that the soap dispenser in her room had been broken for three weeks, despite repeatedly notifying staff at the detention center. Several mothers also reported that they have not been provided with additional soap or hand sanitizer to account for the heightened need for hand washing. One child noted on March 19, 2020 that there was no hand sanitizer available in the dining hall.
19. Several mothers report they have not been provided with adequate cleaning supplies to clean their rooms, which they are required to do. On March 18, 2020, twenty-three mothers stated that they were not provided with disinfectant wipes, and that their requests for disinfectant wipes were denied. One mother reported that she was only given paper towels to clean her room. Another mother stated that she asked CoreCivic staff for cleaning supplies, and was informed cleaning supplies were being rationed because the facility has a short supply.

20. Several mothers reported to DPBP staff that there have been no heightened efforts to clean or disinfect common areas in the detention center. Several families state the bathrooms are extremely dirty. One mother noted that she has only observed detention center staff disinfect areas once per day. Another mother noted that she has never seen the communal computer in the library cleaned or disinfected.
21. Facemasks are generally not available to families at STFRC, not even to individuals who are sick. Families report that although some medical staff at the facility wears gloves, many do not wear masks. Mothers have observed facility staff coughing, and staff who appear to be sick with a fever, who are not wearing a mask. One child reported that she had an appointment with a dentist who coughed throughout their appointment.
22. On March 18, 2020, DPBP conducted a survey with 27 detained families to learn more about STFRC's COVID-19 response plan and implementation. Survey results revealed the following:
 - 18.5% of families surveyed stated the mother or child had a high fever within the last 24 hours;
 - 63% of families stated the mother or child had a new or continuous cough;
 - 40.7% of families stated that someone else in their dormitory presented with a new or uncontrollable cough or high fever;
 - 16.7% of families stated they had encountered a facility employee or visitor who had an uncontrollable cough or apparent fever who returned to the facility after the first day they observed their symptoms;
 - 46.2% of families stated they had not been advised to wash their hands for 20 seconds;
 - 40.7% of families stated they had not been provided with tissues or advised to cough or sneeze into a tissue;
 - 88.9% of families stated they had not been provided with masks, gloves, or cleaning supplies to perform cleaning tasks in their housing unit;
 - 70.4% of families stated they had not been provided with additional soap or hand sanitizer to make it easier to wash their hands;
 - 51.8% of families stated they have not seen facility staff frequently clean and disinfect objects and surfaces that are regularly touched;
 - 81.5% of families stated that individuals who show signs of illness are not provided with a facemask;
 - 81.5% of families stated that individuals who show signs of new or uncontrollable cough, or a high fever, are not transferred to an outside facility or the hospital, and are not placed in isolation; and
 - 85.2% of families stated that potentially infected persons are not grouped together in the same room or housing unit.
23. Families have repeatedly reported inadequate access to medical care at STFRC. Detainees are frequently required to wait two to three hours in a crowded waiting

room in order to speak with a medical provider, and there have been times when DPBP clients have reported waiting eight hours to see a doctor. DPBP clients regularly report they are denied access to medical assessment, follow-up, and treatment. Mothers often tell DPBP staff they fear their child will die in detention due to illness and a lack of medical care. This fear became a reality for one of DPBP's former clients, Yazmin Jaurez, whose 18 month old daughter Mariee died shortly after release from STFRC due to an untreated infection.

24. As of March 20, 2020, DPBP staff was unaware of any mother or child who had been tested for COVID-19, despite the fact that many individuals currently detained at STFRC have flu-like symptoms. This is consistent with our ongoing observation at STFRC over the last four years that detainees are regularly deprived of timely and appropriate medical evaluation and treatment, even in the most egregious of circumstances.
25. Our clients report that sick individuals are intermingled with the rest of the population at STFRC, despite exhibiting a cough, fever, and other COVID-19 symptoms. Seventeen mothers informed DPBP staff on March 18, 2020 that either they or their child had a cough or a high fever, and yet none of them had been tested for COVID-19 or placed in isolation. The same day, eleven mothers reported that there was at least one other person in their dormitory that was presenting with a new or uncontrollable cough or a high fever.
26. On March 19, 2020, two families detained at STFRC reported that eight new families had arrived at the facility that day. Both families reported that one of the newly arrived mothers is exhibiting COVID-19 symptoms and has been provided a facemask. Her child, however, was not provided with a facemask.
27. Failure to test individuals who display COVID-19 symptoms is of particular concern to many DPBP clients. One mother informed DPBP that her five-year-old daughter has experienced fatigue and a severe cough for a week. When the mother sought medical care at STFRC, she was told to give her daughter water, and that there is no cough medicine available for children. The family was not given advisals regarding COVID-19 or tested for it.
28. DPBP represents many mothers and children with pre-existing medical conditions who are particularly vulnerable to COVID-19. Although these individuals are uniquely susceptible to the harms of COVID-19 under any circumstance, many state their condition has deteriorated due to inadequate access to medical care while detained, placing them even at greater risk.
29. DPBP is aware of at least five children with asthma who are currently detained at STFRC. One mother informed DPBP staff that her eight-year-old asthmatic child was transported to a hospital after he was struggling to breathe. Since the child's release from the hospital, however, he has not been provided with an inhaler or necessary follow-up care. DPBP staff spoke to another mother whose seven-year-

old son was diagnosed with asthma while detained. The child's condition has deteriorated significantly during his five months in detention. In early February 2020 the mother sought medical care for her son because he was struggling to breathe. STFRC medical staff refused to provide the child with treatment until the next morning, when his lips turned blue and he required emergency transportation to the hospital and more than 24 hours on an oxygen tank.

30. DPBP represents several pregnant women, including women with complicating factors. For example, O.M.G., a named plaintiff, is six months pregnant. O.M.G. miscarried during a prior pregnancy and has been diagnosed with a vaginal infection while detained at STFRC. Medical staff at the facility has informed O.M.G. that her condition may lead to another miscarriage or birth defects. On March 21, 2020 I spoke with O.M.G. by telephone. During the telephone call I translated the entirety of the "Declaration of O.M.G." into Spanish. I am fluent in the Spanish and English language and swear under the penalty of perjury that O.M.G. confirmed that the information contained in the declaration is true and correct.
31. DPBP represents numerous clients with heart-related problems, including a five-year-old child with a heart murmur that has experienced chronic fatigue, loss of appetite, excessive sweating and lethargy, and a fifteen-year-old child that was hospitalized while in CBP custody for heart palpitations. Another fifteen-year-old child represented by DPBP has suffered cardiac attacks for approximately four of the almost seven months that she has been in detention. The child's mother reports that on numerous occasions her daughter has suffered episodes where she develops heart palpitations, a prickling sensation in her limbs, trouble breathing, dizziness, nausea, sweating, and sudden fatigue. On one occasion in February 2020, while suffering another cardiac attack, the child had trouble breathing and became dizzy. Upon seeking medical attention at STFRC, a medical staff member told the child to "calm down" and only checked her blood pressure after her mother insisted.
32. DPBP also represents numerous children with anemia, including one mother and a son who are both anemic. That mother informed DPBP staff that she sought supplements for her son shortly after they arrived at the detention facility in September 2019 but was turned away from the medical unit. After her son was determined by medical staff to be underweight, he was prescribed Pediasure. The child has not received additional treatment.
33. The above examples are few of many. An additional non-exhaustive list of medical conditions currently experienced by individuals detained at STFRC includes: diabetes, thyroiditis, hyper-thyroidism, tooth infections, vitiligo, epilepsy, gastric liver damage, tachycardia, eye infection, chronic gastritis, and seizure disorder. Medical conditions reported by our clients that are currently untreated and not sufficiently evaluated, or evaluated at all, include: heart palpitations, heart

murmurs, deteriorating vision, undiagnosed lumps with accompanying pain and swelling, kidney inflammation and complications, continued vomiting, severe migraines, numbness in limbs, tumors and ovarian cysts. In addition, there is a child who recently survived a severe skull fracture, a child who is a cancer survivor, and a mother who recently required surgery while detained.

34. Although there are medical providers on site at STFRC, specialists are not available to detainees and the facility is not able to respond to medical emergencies. The facility is 20 minutes away from the Frio Hospital, a very small hospital located in Pearsall, Texas. The Frio Hospital is not equipped to respond to medical emergencies, and the overwhelming majority of individuals who required heightened medical care are transported to a hospital in San Antonio, which is approximately one and half hours away from STFRC.
35. Should emergency medical care be needed to provide care to someone impacted by COVID-19, it is likely they would need to be transported to a hospital in San Antonio. Unfortunately, if one person is infected in Dilley, it is likely the entire population will quickly become infected. If 2,400 individuals required hospitalization at once in San Antonio, the system would become flooded and neither the families detained at STFRC, or individuals who required hospitalization from the community, would have the access and medical care they require.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 20, 2020 in San Antonio, Texas.

/s/
Shalyn Fluharty

DECLARATION OF ALLISON HERRE

I, Allison Herre, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts set forth below are based on my personal knowledge. I can testify competently to them if called upon to do so.
2. I am an attorney licensed in the State of Ohio. I am the Managing Attorney of the Dilley Pro Bono Project (“DPBP”), and have worked for direct the Dilley Pro Bono Project since July 2019. In this capacity, I supervise a team of attorneys, paralegals and volunteers, and provide direct representation to detained immigrant families before the Executive Office of Immigration Review and the Department of Homeland Security.
3. Based upon this experience, I am familiar with the population of asylum seekers that pass through the South Texas Family Residential Center (“STFRC”) and the policies—and changes to those policies—that are implemented by Immigration and Customs Enforcement (“ICE”) and CoreCivic at STFRC.
4. On Monday, March 16, 2020 at 2:00 p.m., Tami Goodlette, Deputy Director of our Project, and I met with ICE Assistant Field Office Director (“AFOD”) Richard Hunt and the ICE Office of Chief Counsel, Deputy Chief Counsel, Emmanuel Garcia. The purpose of the meeting was to learn more about ICE’s COVID-19 response plan, and address access to counsel concerns inherent in our project’s decision to end in-person visitation with clients at the facility.
5. During the meeting I expressed concern regarding the potential spread of COVID-19 at STFRC, and asked AFOD Hunt whether families would be tested for COVID-19. AFOD Hunt explained medical intake procedures would not change, and that medical personnel would continue to briefly screen incoming families during the intake process. AFOD Hunt further

explained that that medical staff would look for worrying symptoms during intake, and if worrying symptoms were identified, families would be “flagged in the system” and sent to the medical residential housing unit for monitoring. If symptoms persist or a person were to test positive for COVID-19 (or any other communicable disease), the family would be moved into a negative pressure room.

6. I asked AFOD Hunt whether COVID-19 testing would be implemented, facility wide. AFOD Hunt stated everyone would not be tested, and that there was no plan for large-scale testing of any sort. AFOD Hunt did not confirm whether COVID-19 tests were indeed available at STFRC, or if any detainees have actually been tested for it.

7. Based upon ongoing conversations with hundreds of families at STFRC, and targeted surveys of clients to learn more about ICE’s response to COVID-19 in practice, we have not identified a single individual who has been tested for COVID-19 or who was placed in a negative pressure room for a suspected of actual COVID-19 infection.

8. When asked what precautions ICE is taking to prevent the spread of COVID-19 in the facility, AFOD Hunt responded that ICE may consider releasing a family with a positive COVID-19 test, but did not commit to release occurring. AFOD Hunt explained that the facility would continue to clean the facility in accordance with its prior practice, which includes wiping down toys in the play area three times per day.

9. AFOD Hunt also stated that self-serve stations in the dining hall would be staffed by contracted personnel, who wear gloves and dish out food to detainees. This is the only change AFOD Hunt indicated was being implemented at STFRC in response to COVID-19.

10. I have reason to believe that the three things identified by AFOD Hunt as part of STFRC’s COVID-19 response plan (medical screening on the bus with further observation of

individuals who present COVID-19 symptoms, cleaning of toys three times a day, and contracted personnel taking over the self-serve food lines in the dining hall), have not been consistently implemented, if at all. Based upon detailed conversations with DPBP clients, it does not appear self-serve lines have been staffed by a contractor. Numerous clients have informed DPBP that the self-serve lines in the dining hall are still in operation. We have also received reports of CoreCivic staff refusing to wipe down toys and withholding sanitizing wipes from residents upon request. Additionally, we have heard from mothers who have taken children to medical with worrying symptoms, including new and uncontrollable coughing and a high fever, that they have not been seen by a doctor, tested, or provided with any medical treatment and that individuals who arrive to STFRC with a cough – which is very common – are not placed in isolation.

11. During our conversation about ICE's COVID-19 response plan, AFOD Hunt failed to detail any plans for staff or detainee education about the COVID-19 virus, changes to staffing plans for STFRC medical or custody staff, and changes to staffing for cleaning the facility. AFOD Hunt also did not mention any steps in increase detainee hygiene and hand washing, coordination with hospital or outside medical providers in case of an outbreak, screening for COVID-19 exposure (rather than just symptoms), changes to sleeping arrangements at the facility, additional precautions for vulnerable populations, procedures to implement social distancing amongst detainees, or the provision of masks, new cleaning supplies, or gloves to staff or detainees.

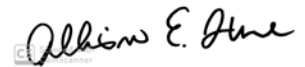
12. I expressed significant concern for detained families with pre-existing medical conditions who are uniquely vulnerable and at risk of death if infected by COVID-19. Specifically, I noted the possibility that infected individuals who are asymptomatic may come

into contact with other detainees with pre-existing conditions. AFOD Hunt informed me ICE has no plans to release medically fragile detainees, and that ICE planned, to instead, isolate infected (or potentially infected) individuals to prevent the spread of the virus to medically vulnerable individuals.

13. On March 20, 2020 I received a phone call from AFOD Hunt informing me that ICE has, or will, release medically vulnerable families who are detained at STFRC. DPBP maintains a non-exhaustive list of clients who we have identified as medically vulnerable. Our current list includes approximately 100 individuals. As of March 21, 2020 I am not aware that any of these individuals have been released from STFRC.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 20, 2020 in San Antonio, Texas.



Allison Herre

Declaration of Stephanie Alvarez-Jones

I, Stephanie Alvarez-Jones, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a staff attorney and Justice Catalyst Fellow with the Dilley Pro Bono Project (“DPBP”), where I have worked since September 2019. I am an attorney licensed to practice in the State of New Jersey.
2. Part of my regular duties involve meeting with and speaking with families detained at the South Texas Family Residential Center (“STFRC”) in Dilley, Texas. I meet with clients at STFRC at least once a week.
3. Ever since I started working with the Dilley Pro Bono Project in September 2019, the process to enter the detention facility has largely been the same. For example, in February 2020, when I entered the security trailer at STFRC, I was required to place my belongings in a bin which was then passed through an x-ray machine. I then had to walk through a metal detector. After collecting my belongings, I was required to sign into the visitor’s sign-in sheet. I am required to list my name, the organization with which I am affiliated, my driver’s license number, and the time of my entry. I then exit the security trailer, walk through a covered walkway into the legal visitation trailer.
4. There was nothing different about the entry procedure when I entered STFRC on Tuesday, March 17, 2020. When I signed in, I was not asked to provide any additional information. I was not asked whether I had a cough or fever; whether I had traveled outside of the United States in the last fourteen days; whether I had traveled to an affected area in the last fourteen days; whether I had come into close contact with someone who had COVID-19 in the last fourteen days; or if I had any contact with someone who had travelled outside of the United States. At no point was my temperature taken during my 11-hour visit at STFRC that day. At no point was I offered or asked to wear a face mask or gloves. At no point was I asked to wash my hands.
5. The only difference I noticed on Tuesday, March 17, 2020, was a laminated notice on the door to the legal visitation trailer. This notice was from the Federal Bureau of Prisons regarding the COVID-19. It recommends that individuals with cough or fever not enter the facility.
6. Upon entering the legal visitation trailer, I walked to a table at the far end of the visitation trailer. I observed four Core Civic guards in the legal trailer. None of them were wearing face masks and none of them were wearing gloves.
7. I met both individually with clients and with large groups of clients on Tuesday, March 17, 2020. At no point did I see anyone – other DPBP staff, detention facility staff, ICE

officers, or women and children – wearing face masks. The cleaning crew did wear gloves, as they usually do.

8. On March 21, 2020, I spoke with C.L. by telephone. During the telephone call I read the entirety of the “Declaration of C.L.” in English to a certified Haitian Creole interpreter, who translated from English into Haitian Creole. I swear under the penalty of perjury that C.L. confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed March 21, 2020 in Dallas, Texas.

A handwritten signature in black ink, reading "Stephanie Alvarez Jones". The signature is written in a cursive style with a large initial "S".

Stephanie Alvarez Jones

DECLARATION OF ANDREA MEZA

I, Andrea Meza, swearing under penalties of perjury, make the following declaration:

1. My name is Andrea Meza and I am an attorney and the Director of the Family Detention Services Program at the Refugee and Immigrant Center for Education and Legal Services (“RAICES”). I have been the program Director since March 2019. Prior to my position as Director I served as the Associate Director from October 2018-March 2019. From September 2015 to July 2017 I was an Equal Justice Works Fellow and provided direct legal services to families at Karnes. I have been licensed in the state of Texas since November 6, 2015.
2. RAICES, with volunteers and pro bono attorneys, has provided free legal services at Karnes County Family Residential Center in Karnes City, Texas (“Karnes family detention center” or “Karnes”) since its opening as a family detention center in August 2014. In 2018, RAICES provided legal services to over 8,000 people detained at Karnes. RAICES’ Family Detention Services program strives to provide free, universal representation through all phases of the immigration process during detention at Karnes.
3. RAICES is the primary non-profit legal services provider at Karnes, the only pro bono legal services organization operating on the ground at Karnes, and the primary source of free legal representation for Karnes detained persons. RAICES estimates that it provides free legal services to between 80-95% of the population at Karnes.
4. The Karnes family detention center is located in Karnes City, Texas, which is a small town about an hour southeast of San Antonio. The town of Kenedy, Texas is the slightly larger town about a ten-minute drive away from Karnes City. The hospital closest to the Karnes family detention center is the Otto Kaiser Memorial Hospital in Kenedy, which has about 25 staffed beds. I have heard of several cases when individuals detained at Karnes were first taken to Otto Kaiser, then transferred to a larger more intensive hospital in San Antonio, Texas.
5. I have visited the Karnes family detention center hundreds of times to meet with clients since 2015. I have heard complaints about medical services at Karnes for years. The

population at Karnes generally is released from detention within 4-6 weeks, but at various periods of time, the population has been detained for months at a time. No matter the circumstance, the complaints I have heard about the inadequacy of medical services at Karnes remain the same. There is no pediatrician or OB-GYN on staff at Karnes. Families report being attended to by nurses who pay their complaints little heed.

6. I have had a stakeholder relationship with ICE Assistant Field Office Directors at Karnes throughout my work with RAICES. In January of 2020, Anthony Hofbauer became the Assistant Field Office Director at Karnes. Assistant Field Office Director Anthony Hofbauer (“AFOD Hofbauer”) and I have maintained regular communication about changes at Karnes. Since he began his position at Karnes, AFOD Hofbauer has attempted to make changes to improve conditions at Karnes. However, these attempted improvements have often been thwarted by the culture of indifference and fear that permeates the GEO and ICE staff at Karnes, and also by restraints inherent to the facilities and design of the Karnes family detention center.
7. Karnes was originally built to detain single adult men. It is a secure, prison-like setting, though through the years of its existence as a family detention center, cosmetic changes have been made, such as painting murals and hanging colorful art on the walls. The doors are heavy metal doors that require pushing a button to request entry or exit. Many have only very small windows. I have never been permitted entry into the space where detained families are held beyond the main visitation room. From what I can see through a window in the visitation room, and from what I have heard from clients, GEO, and ICE, Karnes is set up in square units surrounding courtyards. Playgrounds were added to the courtyards when the detention center began to imprison families. Cells where families sleep have bunk beds, a TV, and a small table inside, and my understanding is that multiple families share a single bathroom, and often share a room. The cells are organized into “patios”, and there are a few shared recreation rooms. There is one cafeteria, one library, and one medical unit for the entire detention center. An additional wing of cells and a courtyard were added to Karnes after it became a family detention center, but I am not aware that any additional cafeterias, libraries, or medical units were

constructed. I regularly hear clients, GEO, and ICE refer to these spaces in the singular, such as saying that a client is “in medical” or “needs to go to medical.”

8. The visitation space at Karnes consists of a main room a bit larger than a typical school classroom, surrounded by five private rooms. Three of those rooms are equipped with a telephone. In order to enter the visitation area from within Karnes, detained persons must pass through a “sally port” type hallway that connects the outdoor courtyard to the main visitation room. Where the door from the sally port meets the main visitation room, there is a desk set up where one to three GEO staff sit and monitor visitation. Detained persons are not permitted entry into the main visitation room without permission from GEO staff. There are several tables and chairs set up in the main visitation room, but meetings at these tables are not confidential because GEO staff is present at their desk in the main visitation room. Additionally, many GEO and ICE employees use the visitation space as a means for their ingress and egress between the main part of the detention center where families are held and the lobby and main entry hallway of Karnes that connects to ICE and GEO administrative offices. There is frequently regular foot traffic throughout the day in the main visitation room.

9. In my years providing legal services to families at Karnes, I have heard consistent complaints about the medical services provided by GEO. Detained persons regularly complain that their needs are not addressed in the medical unit. Over the years, when I have brought up complaints about medical services to ICE, supervisors regularly state that medical services are available 24 hours on a walk-in basis. They indicate that therefore, complaints about the availability and quality of medical care are unfounded. However, clients specifically state that there are prohibitively long waits at the medical unit. For years clients have told me that they have waited hours at medical without being attended to. They additionally state that often, medical staff ignore their needs. Detained persons regularly report that medical staff dismiss their concerns or say that there is nothing that can be done for the reported ailment at Karnes. The most commonly reported recommendations from medical staff include the following: ibuprofen, cough syrup, water, and eating more food. RAICES has represented clients with cancer, brain

damage, diabetes, HIV, and many women who recently suffered rape or miscarriage, who have reported deficient or no medical care at Karnes.

10. On March 13th, I spoke with AFOD Hofbauer over the phone about changes in visitation at Karnes given concerns about the COVID-19 virus. This was the first of several times that I spoke with the AFOD about COVID-19 and its impact on Karnes. AFOD Hofbauer informed me that he had just received word through “executive order” which prohibited community visitors. AFOD Hofbauer informed me that legal visitation would continue at Karnes.
11. AFOD Hofbauer stated that the changes to legal visitation would consist of the following: legal visitors would be subjected to a temperature check and a short questionnaire on a daily basis.
12. AFOD Hofbauer told me that he would offer skype and facetime options for legal visitation beginning on Monday March 16th. He said that GEO did not yet have the iPads for these video visits, so legal visitation could be conducted by phone over the weekend.
13. I asked AFOD Hofbauer how many rooms would be available for legal video calls and he told me that there wouldn’t be many, given the space constraints at Karnes. He said that if we needed more iPads, he would ask the GEO Warden if the request could be accommodated.
14. AFOD Hofbauer told me that there was a “possibility [ICE] might not be going to work either, we might be teleworking.”
15. On Sunday March 15th, I emailed AFOD Hofbauer to see if he had an update in protocol regarding COVID-19. He stated:

Morning, we have identified more tablets if you all prefer that method. I’m waiting to hear back from the Warden to see if the thermometer has arrived but all else is the same.We have about eight tablets available and we can utilize all the offices in visitation, if needed. We will make every attempt available to ensure the meetings are confidential. I have attached the [legal visitation] screening questionnaire, as requested.

16. On Tuesday March 17th, I had a meeting with AFOD Hofbauer over the phone for a little more than an hour. He informed me that there were two iPads available for FaceTime calls and six other iPads that were not yet functional. He said that detained persons would be able to use iPads in visitation, he suggested they might be able to use them in their dormitory cells, and said that they likely could not use them in private courtroom areas because of staffing needs to monitor that space.
17. I asked AFOD Hofbauer about plans to address COVID-19. He stated that he was in “close communication” with Karnes County officials, the CDC, and the ICE Health Services Corps. He said that there were “no concerns, no cases for COVID-19.” When I asked him if he had a plan for what would happen if someone were to test positive he said he had some guidance, but that it would be a new situation for all involved if someone were to have COVID-19.
18. I asked AFOD Hofbauer how they were testing for COVID-19. He told me that they were taking temperatures of detained families while they were in the carport before they even entered the detention center, and asking a few questions. He indicated that he did not have access to tests for COVID-19.
19. AFOD Hofbauer has thus far proven to be helpful and accommodating to us, and I expressed appreciation for that. I asked him frankly if he was concerned about his staff given the President’s warning not to congregate in groups of more than ten people, and I asked him if there were plans to “shut down” Karnes. AFOD Hofbauer expressed that he and others at ICE were concerned about spread of the virus and had raised those concerns through their channels, but that he and his superiors were waiting on guidance from ICE Headquarters as to how to respond.
20. I received the AFOD’s response as sincere and concerned. AFOD Hofbauer has demonstrated that he is very reasonable and understanding, unlike many other ICE officials I’ve encountered, even officials with whom I considered myself to have a decent working relationship. My impression is that the AFOD is, quite reasonably, concerned about the safety of all who are in Karnes, but that he has not been given the authority to address the issue as he would like to see it addressed.

21. I directly asked the AFOD if he had considered releasing people from Karnes given concerns about large groups and COVID-19. I told him that in the past, RAICES has helped ICE facilitate release of families, and that we were willing to work with ICE to do so in the event that release is ordered. I mentioned that in December of 2016, there was a mass release that was poorly coordinated and that we were interested in working with ICE to avoid a similar situation. When I pressed AFOD Hofbauer regarding whether he had considered releasing all families at Karnes he said: “Unfortunately I can’t comment on that, I wish I had the ability to do that but I can’t comment on that.”

22. I then asked AFOD Hofbauer a series of questions related to the COVID-19 response:

- a. First I asked whether the facility had a written exposure control plan approved by a physician. AFOD Hofbauer responded that he did not have a plan, but he said that GEO had a written plan in the event of an exposure. I asked when the plan was last reviewed and updated and he stated that he would have to ask GEO.
- b. I asked if there were any updates in protocols for medical, dental, and laboratory equipment and instruments to be appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations. AFOD Hofbauer responded that GEO goes above and beyond in cleaning and that Karnes is one of the nicest facilities he had ever seen. The AFOD told me that there are full cleanings two to three times daily. He stated that detained families do additional cleaning in their rooms themselves. AFOD Hofbauer said that because of the alcohol level in hand sanitizer, he could not provide hand sanitizer to the families because of the Family Residential Standards, but he said that there was “plenty” of hand soap.
- c. I then specifically asked who cleans the rooms. AFOD Hofbauer told me that GEO staff and detained persons clean the rooms, and that detained persons help clean the facility generally. I asked if there had been any changes to the cleaning solutions used and he said that the solutions were formulated according to standards that are uniform across the country. He stated that the standards allow for a certain percentage dilution with water.

- d. I asked if there were protocols for biohazardous waste disposal and the AFOD did not have that specific information available.
- e. I asked AFOD Hofbauer if he was aware of anyone currently in medical isolation. He said that there were some cases of people in observation based on CDC guidance based on countries through which they had traveled. I asked what “observation” meant, and he told me it meant that they cannot leave the medical unit. He said that they would be on a 14 day observation period. I asked him if entire family units were in observation together, he said yes.
- f. I asked AFOD Hofbauer if there is there a functional negative pressure room for patients requiring respiratory isolation. AFOD Hofbauer said that there are “more than five” negative pressure rooms. He indicated that there are two medical areas, but I did not follow up and ask whether that meant that there are actually two medical unit clinics where detained persons may receive services. As mentioned above, I am only aware of the existence of one medical unit clinic where detained persons may receive services.
- g. I asked what procedures are used to disinfect bedding and clothing. AFOD Hofbauer indicated that was a question for GEO, but that he did know that when a family leaves and a new family is going to come in, that the room is “deep cleaned” before the new family enters, and that sometimes this even causes a delay at intake as there is a wait time to go to the room while it’s thoroughly cleaned.
- h. I asked AFOD Hofbauer what considerations are taken for pregnant women and children in terms of treatment. He implied that release of families including those with pregnant women, children, and those with health concerns was being evaluated on a case by case basis, but that there was currently no guidance to generally release pregnant women.
- i. I asked AFOD Hofbauer how often environmental health inspections are conducted. He said that there is a yearly safety inspection, that GEO does a daily

inspection of all rooms as part of their shift, and that there are monthly inspections and other regular inspections by outside authorities.

- j. I asked AFOD Hofbauer if there were any changes in the protocols for cleaning food, utensils, and dishes. He said that the same standard for sanitizing dishes that is specific to family residential centers remains in use.
- k. I asked AFOD Hofbauer if there were specific screenings for people with respiratory illnesses such as asthma. He said that there are regular medical screenings at intake, and that the medical unit is open 24/7. I mentioned that clients often tell us about long wait times at medical, and he said that receiving services should be “automatic.”
- l. I asked whether there are facemasks, gloves, and cleaning supplies available. He said that these items are available for officers, and that GEO has them as well, but that they will be available in case of an emergency situation. AFOD Hofbauer indicated that if our staff were present and someone were to have COVID-19, that ICE would make surgical masks available temporarily to our team.
- m. I asked what precautions are taken in terms of aerosolized treatments that may adversely affect persons with chronic respiratory diseases. AFOD Hofbauer indicated he was not aware of any specific precautions. He said that medical had higher grade cleaners than what is used in sleeping areas.
- n. AFOD Hofbauer asked the supervisory deportation officers, who report directly to him, if there were other precautions in place. He said that besides the tests (temperature tests and questionnaire), it appeared that most things were going on as usual.
- o. AFOD Hofbauer indicated that the biggest change at the detention center was education, meaning giving the families detained information about the virus and the need for more frequent hand washing.

- p. I asked if there were handwashing stations set up for people before entering the cafeteria, and AFOD Hofbauer said that the only stations available were in their rooms and in any restroom.
 - q. My colleague, Javier Hidalgo, our team's supervising attorney, asked AFOD Hofbauer if there had been any scale back on staff. The AFOD said that school is up and running and that there haven't been any issues with employees not showing up for work.
 - r. I asked if sick leave was available for staff, and AFOD Hofbauer stated that it is.
23. From Monday March 16th to Thursday March 19th, the staff that I supervise reported a number of concerning deficiencies, and that they observed very few precautions being taken by GEO or ICE at Karnes. They observed GEO and ICE employees shaking hands with each other, and even joking about their colleagues who were working at Karnes while exhibiting flu-like symptoms. Our staff also reported that upon entry to Karnes, their temperature is taken and they must complete a survey about their recent travel, however no Karnes staff members are wearing gloves or masks when they are reviewing identification or personal items, and that counters and commonly touched surfaces in the entrance do not appear to be wiped down or disinfected apart from regular cleaning. Detained persons used phones in visitation and there were no cleaning supplies available to wipe down phones, tables, or chairs between use. Toys in the visitation area were not cleaned between use, and the GEO staff in visitation handle detained persons' identification cards but did not use gloves or take any additional sanitary measures.
24. During this time, staff reported that detained persons repeatedly raised serious concerns about their and their families' health at Karnes. Nearly everyone that our staff spoke to expressed concern that many children were suffering from diarrhea and vomiting, that pregnant women were not receiving appropriate care, and that everyone – though in particular, children – were losing alarming amounts of weight. Detained families expressed fear about the threat posed by COVID-19 and the lack of appropriate precautions taken at Karnes. They report that cafeteria staff do not wear masks, that

requests for masks or gloves by detainees to Karnes staff are denied, and that detainees are not provided soap and must purchase it from the commissary.

25. On March 20, 2020 around 6:00 PM, AFOD Hofbauer called me to give me further updates about the COVID-19 response at Karnes. He clarified that masks and personal protective equipment would only be available in the event of an emergency. He said that he does not have a lot of resources because of the demand for masks around the country.
26. AFOD Hofbauer told me that there would be additional changes at Karnes due to an order from the Governor prohibiting gatherings of more than ten people. He said that legal visitation would continue, but that there would be no person to person contact. AFOD Hofbauer indicated that in order for us to conduct in-person visitation at Karnes, we would have to wear gloves, masks, and protective eyewear.
27. AFOD Hofbauer indicated that at some detention centers, legal visitation could function with one attorney in a visitation room then “the other across the hall” but that such an arrangement was not possible at Karnes because of the limited space for legal visitation at the detention center.
28. In this conversation AFOD Hofbauer stated “We’re [employees and legal visitors] the ones on the outside; we’re a risk to them [detained families], not them to us.”
29. AFOD Hofbauer stated that with the governor’s new restriction, we could meet with no more than ten people in visitation at any given time.
30. I asked AFOD Hofbauer what would happen at meal times. He said, “That is a good question. Yeah we’re gonna have to figure something out... feeding times will take forever. We’re going to be eating all day. I’d have to check with the warden because that’s more of a facilities issue.” He opined that grouping detained families together in settings of more than ten people might not be problematic because they are people who have already been in contact with each other, as opposed to outsiders coming into the detention center. It is evident to me that while AFOD Hofbauer may be doing his best to address the COVID-19 threat within his authority, that he has received very little practical guidance as to how precautions for families and staff at Karnes may be

implemented in a detained prison setting. His responses to me indicate the impossibility of full compliance with the most protective measures as recommended by the CDC and local authorities.

31. Staff who visited Karnes on Friday March 20, 2020, when GEO began to implement the 10-person rule in visitation, reported that deficiencies in application of precautions for COVID-19 continued. Their observations demonstrate that it is impossible for necessary precautions to be effectuated in a detention center environment, especially with a family population.
32. Although it is my understanding that schools have been ordered closed in the State of Texas, as of March 20, 2020 children at Karnes continued to attend the school inside the detention center, making social distancing impossible.
33. Additionally, staff who visited Karnes on March 20th observed that GEO interpreted the 10 person rule to mean that no more than ten clients could be present in the main visitation room at a given time. It did not appear that GEO staff or RAICES staff were counted in that ten person limit. Because of requirements that family units remain together during the day, most families arrive together for a legal visitation appointment. However, because of the 10 person rule, only one representative of the family can enter the large visitation room at a time. The rest of the family was forced to wait in the small “sally port” room. This meant that more than ten people from multiple families were cramped into a small space while they waited for one person from each of their families to meet with legal representatives.
34. Our staff observed that a play carpet in the main visitation room was removed, so babies were forced to play on the hard floor. Staff observed adult clients suffering from constant cough during their legal visit. They observed the near impossibility of avoiding touching one’s face, especially for those with babies and small children, who often sit in their parents’ laps. They saw, during a GEO shift change, that many GEO employees were crowded shoulder to shoulder in the main entry hallway waiting to clock out and leave.

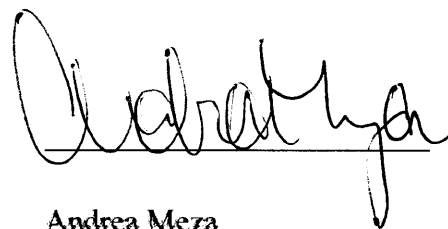
35. My experience over the years at Karnes and our RAICES staff's experience this week indicate that it is inherently impossible to effectively implement adequate safety precautions for COVID-19 at the Karnes detention center. The medical care has been deficient for years, as Karnes has never invested in building a culture of care, given the **fact that typically, most families are not detained long enough for GEO to be held** accountable for their inattention to detained persons' medical needs. The medical staff at Karnes is not equipped to respond to a pandemic situation. The remote location of Karnes means that an outbreak of COVID-19 will decimate the detained population and will immensely impact care available to the local community. The physical construction of Karnes as a prison makes it impossible for social distancing measures to be implemented. Families are constantly in close contact with each other and with staff who come in and out of the detention center daily. Even if the extreme measure of a quarantine of family units to individual rooms were taken, bathrooms are shared, and children, babies, and pregnant women would be forced into effective solitary confinement, which would amount to torture.

36. The detention setting of Karnes is a serious public health concern not only for the families detained there, but also for ICE and GEO staff who are not equipped to take necessary precautionary measures at Karnes. It is impossible to keep staff and detained families in Karnes safe from the threat of a serious COVID-19 outbreak as long as the detention center remains open.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020

San Antonio, Texas

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

Andrea Meza

DECLARATION OF JULIA MARCELLA VALERO

I, Julia Marcella Valero, swearing under penalties of perjury, make the following declaration.

1. My name is Julia Marcella Valero and I am the Karnes Pro Bono Volunteer Manager for the Karnes Pro Bono Project, under the auspices of RAICES. Prior to becoming the Karnes Pro Bono Volunteer Manager in October 2019, I provided legal assistance as a Legal Assistant under the auspices of RAICES to the migrants detained at the Karnes County Family Residential Center, previously named Karnes County Residential Center, ("Karnes") since June, 2018. I have been coming to Karnes to provide legal services since June, 2017, when I provided legal services as a legal assistant undergraduate intern with RAICES.
2. I have extensive experience working with migrants in immigrant detention. I have met with and provided legal services to more than a thousand individuals detained in Karnes as they fought their deportations and detention, including mothers with minor children, fathers with minor children, single adult women, and nuclear family units consisting of mother, father, and minor children.
3. Almost every family I have met with in Karnes this week has expressed concern about the possible spread of COVID-19.
4. Not a single family I have met with this week in Karnes has been healthy.
5. Multiple families have expressed fear that they may die if COVID-19 comes to Karnes due to the lack of adequate medical care.
6. Multiple families have expressed that Karnes' medical care is not adequate for basic medical needs such as headaches and the common cold, and so families express that they are even further worried about Karnes' capacity or desire to provide families with medical treatment for the virus if infected.
7. Not a single family I have spoken to has had access to hand sanitizer, a protective mask, or gloves.
8. Multiple families have expressed frustration with their lack of access to basic cleaning materials such as soap.
9. Multiple families have expressed concerns about how GEO staff disturbs families' sleep. Many families say that GEO aggressively checks on the families at night, and families expressed that these disturbances affect their health negatively. On the night of March 18, 2020, multiple families stated that GEO was especially aggressive in checking on families following the suicide of a father in Karnes. Despite concerns about COVID-19, GEO staff went in and checked families' pulses with their bare hands, with no gloves used for protection, no 6 foot rule observed, and no consent from the families.
10. Multiple families have also expressed fear of the virus spreading quickly in Karnes because families are housed in shared rooms and cannot remain 6 feet apart for social distancing within the constraints of detention. Multiple families have expressed that they are forced to remain in close contact with each other when eating together in the shared cafeteria, when in line for the cafeteria and the medical center, and when in their shared bedrooms. Multiple families have expressed that the cafeteria is crowded. One family estimated that

approximately 120 people fit into the cafeteria during mealtime, and the cafeteria fills to capacity as people wait outside in line to be able to eat.

11. I have seen multiple GEO guards shake hands, not abide by 6 feet of social distancing in line to clock in or clock out. I have not seen a single GEO guard wearing gloves or a protective mask this week. I overheard GEO medical personnel saying this week “we never know anything until the very last.”
12. I witnessed my colleague Dinorah Galeana be denied entry into Karnes on March 19, 2020 because she has traveled out of the U.S. in the last 14 days. When Dinorah raised that she had been allowed entry into Karnes on March 17, 2020 and had met with families after disclosing that she was outside of the U.S. in the last 14 days, Officer Cisneros admitted that Dinorah should not have been allowed entry on March 17, 2020. Officer Cisneros called this a “mistake.”
13. I have met with many families who are unable to stomach the food in Karnes. Many families express that the food has caused them vomit, diarrhea, and nausea.
14. I have recently met with at least three families with children under two who are not eating and are very ill. Their families have tried to access medical care for them but they are not receiving care in Karnes.
15. I have recently met with multiple women with severe pregnancy complications that are not being treated in Karnes. The women I have spoken to have all tried to get help at the medical center in Karnes but they are not receiving care.
16. I have met multiple families in Karnes who express that there is an attitude of “stay silent and sign” in terms of GEO group complying with its obligations for care of the families. Multiple families have expressed that there is an attitude from the prison guards that they must sign the forms (the forms acknowledging they have eaten in the cafeteria, the forms acknowledging they have seen a mental health provider, etc.) but that the GEO officers (including medical officers) do not care if the families are actually being cared for. Multiple families have independently told me that they believe this is GEO group abiding by its obligations without care for how families are actually doing.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020

San Antonio, TX



Julia Marcella Valero

DECLARATION OF LAILA AYUB

I, Laila Ayub, swearing under penalties of perjury, make the following declaration.

1. I am a staff attorney at RAICES. I regularly make legal visits with families detained at the Karnes County Residential Center in Karnes City, Texas. Typically, I spend about 10 hours there, two to three times a week. The following are my firsthand observations and recollections from conversations with families and staff at Karnes.
2. On March 9 and 11, 2020, I made legal visits to Karnes. Between those two days, approximately six families organically shared with me that their children have stopped eating within preceding two weeks. Three fathers specifically expressed concern that their children, two three years old and one six years old, have been losing weight as a result of not eating.
3. One father described his three-year-old son as “skin and bones.” He told me that he took his son to the medical center because of the weight loss. He told me that the medical staff just weighed his son and told him that it is normal for a young child to not eat a lot of food, and that it is okay for a young child to not be gaining weight.
4. Other fathers told me similar stories. They took their children to the medical center because they were not eating, and the GEO medical staff weighed their children, and said that the children were doing fine.
5. One father told me that his son has lost seven pounds since being detained.
6. Each of the fathers I spoke with told me that their children never had problems eating prior to detention. They also had not experienced weight loss like this prior to detention and were growing normally before their detention.

7. I visited Karnes on March 18, 2020, for the first time since ICE announced changes to visitation procedures at Karnes.
8. When I entered the building that day, I was allowed to go through security to the front desk as I normally would. I placed my belongings on the conveyer belt and walked through to the front desk to check in.
9. GEO staff took my temperature with a no-contact thermometer and had me fill out a questionnaire. GEO staff did not explain anything to me. They did not ask me to wash my hands. They were not wearing gloves. I handed them my license as I normally would, and they handed me a visitor badge. They placed my license in a binder along with those of all other staff and visitors in the building. They told me I could enter the visitation area to begin meeting with clients.
10. When I walked into the visitation room, at approximately 9:40 am, a group of detained fathers were cleaning the restrooms and high traffic tables, doors, and windows. The only protective gear they had was gloves. GEO staff were telling them what to clean.
11. Throughout the day, GEO staff were touching all of the surfaces on tables and the front desk and standing within close proximity to one another. They lined up within inches of one another on the hour to clock in and out from their shifts. They use a touch screen to do this. I have never seen someone clean the touch screen.
12. I noticed that I could not avoid touching certain surfaces with my hands throughout the day. For example, I have to open two doors to get into the visitation room. The second door requires me to press a button so that someone can unlock the door remotely. The trash can in

the visitation room requires me to use my hands to close it. The doors to the rooms where I meet with clients cannot be opened without using my hands.

13. I have not seen any of the children's toys in visitation get cleaned, nor phones or tablets that are used for family visits. As far as I know, there is no protocol in place for cleaning these surfaces before or after client meetings. Clients had to use phones and tablets to be able to speak to RAICES staff for remote legal visits. I took it upon myself to wipe these down between clients.

14. GEO guards handled families' identification cards with their bare hands. I did not see them getting up to wash their hands frequently.

15. ICE staff came very close to me to speak with me, multiple times throughout the day. They were within a three feet distance from me. The only apparent precaution they took was to tell me they could not shake my hand.

16. The waiting room to get into visitation was full of families sitting in chairs immediately next to each other.

17. The rooms in visitation require that we sit across the table from the person with whom we are meeting. I would estimate that we are about a foot or two apart from one another, sitting face to face.

18. GEO staff required families to line up to head into the cafeteria as usual, in two parallel single file lines, with no more than an arms distance between each other. The fact that families line up at meal times indicates that they are required to all eat at once. I would therefore assume that the cafeteria is full of people at meal times.

19. Children were still attending school throughout the day as usual, and going to the daycare.

20. Clients told me that they were being called one by one to meet with officers to sign forms about coronavirus. They said that these forms seemed like a way for staff to put on a facade of having explained coronavirus and taken the necessary precautions, but they did not actually explain it to them.

21. In the afternoon, a large group of families tried to enter visitation at once to speak with RAICES attorneys. GEO staff did not let them speak to me. GEO did not ask the group to disperse, even though they were very crowded in a small room and standing close to each other. In fact, GEO staff also got very close to the group of families.

22. Every family I met with during the day organically told me that children are sick, many are vomiting and have diarrhea. They told me there have been several children and fathers with fevers but that they do not get removed from housing units, most people are still living in their rooms with other families.

23. In the evening, a toddler came up to me and touched me, so as to try and play with me. The child was clearly too young to be able to grasp the concept of taking precautions against a virus. Because it was the evening, the daycare was closed, which means that the child had to accompany his parents while they spoke with RAICES attorneys. Because of the size of the room, there was no appropriate space for the child to be able to distance himself from me or vice versa. It also seems inhumane to have to think about communicating to a toddler that he needs to move away from me in order to keep an appropriate social distance. The same child

approached a GEO staff member. The GEO staff member did not take any care to avoid touching the child or create space between himself and the child.

24. I cannot imagine how this situation would be avoided within the setting of Karnes. I believe that the only appropriate preventative measure for that toddler and other children at Karnes would be for him to live outside of detention, in a setting where his parents would be able to exercise the power to make decisions to protect their child's health and safety.

25. I am afraid that I could unknowingly carry the virus to the families I meet with at Karnes because of the above stated observations.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 21, 2020 in San Antonio, Texas.



Laila Ayub

Declaration of R.P. [REDACTED], A2 [REDACTED] 1-613

I, R.P. [REDACTED], declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

1. My name is R.P. [REDACTED]. I was born in Port Au Prince, Haiti on April 6, 1986. I am 33 years old and currently detained in ICE custody at the Karnes County Residential Center with my pregnant wife, R.M. [REDACTED], A#213-211-614, born on November 4, 1997 in Ouanaminthe, Haiti and my one year old son, V.P. [REDACTED], A# [REDACTED] 1-615, born on April 10, 2018 in Port Au Prince, Haiti.
2. I am not too comfortable here. Most of the people here are women and children, many of whom are already sick or not eating well. We are all worried that if the virus reaches this detention center, many people could die. The GEO officials have not said anything to us or shared important information about safety. Everything that we know has come from the news that we watch. The officials have been silent.
3. I believe that if my family was able to be released and continue my case outside of detention, we would have a better chance of staying healthy. The doctors here are already not able to protect us. The doctors say they are already busy and they are frequently unable to take care of our current needs. My wife, for example, is sick and has ovarian cysts. She is in lots of pain and has gone to the doctors here many times but has been told treatment is not available. She has not had her period in over 5 months. If this is how this center handles routine medical care, I fear for our lives if the virus reaches us and we are stuck here.

A#: [REDACTED] 1-613

R.P. [REDACTED]

I, [REDACTED], swear under penalties of perjury that the above declaration is true and accurate to the best of my abilities. This declaration was read back to me in Haitian Creole, a language in which I am fluent.

R.P. [REDACTED]

Signature

3/16/20

Date

CERTIFICATE OF INTERPRETATION

I, Matthew Bratek, certify that I speak English and I read the foregoing in the English language to Ruth, a certified telephonic interpreter in the English and Haitian Creole languages. The interpreter read the foregoing in the Haitian Creole language to [REDACTED] before the declarant signed it.

Matthew Bratek

Signature

3/16/20

Date

2511 Texas 1604 Loop, #201
San Antonio, TX 78258
Interpreter Address

(855) 571-8342
Interpreter Telephone

Declaration of T.F. [REDACTED] A#213-211-563

I, Tanie Francois, declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

1. My name is T.F. [REDACTED], A#213-211-563. I was born on May 17, 1983 in Haiti. I am 37 years old and currently detained in ICE custody at the Karnes County Residential Center (“Karnes”) with my husband, A.R. [REDACTED], and our two children, B.F. [REDACTED], 4 years old, and D.F.R. [REDACTED], 19 months old.

MY BABY’S HEALTH HAS DETERIOTED SINCE BEING DETAINED AT KARNES

2. Since we arrived at Karnes, my baby’s health has deteriorated. I first noticed she was struggling to breathe at night while she slept. She becomes easily congested and begins wheezing. As a result of her difficulty breathing, she wakes up in the middle of the night crying and cannot fall asleep. Her lack of sleep is also concerning because it puts her at an increased risk of becoming ill from coronavirus (“COVID-19”). I feel like she is in pain.
3. I visit the medical center at Karnes every day, so the medical staff can care for her. However, I do not trust that they care. The doctor at Karnes, whose name I do not know, told me that D.F.R. [REDACTED] has secretion in her lungs that’s causing her breathing complications but that it was normal. They also tell me that her weight is normal when in reality, she’s lost about 7 pounds since we arrived at Karnes. She used to weigh about 33 pounds (15 kilograms) but now weighs about 26 pounds (12 kilograms). This kind of weight loss is not normal for a baby. If I cannot trust the medical staff to tell me the truth about her weight loss, I cannot trust that they care about our health.
4. When she first began to exhibit breathing problems, the medical staff used a machine to get the congestion out of her lungs. After telling me the machine was no longer necessary, they took her a hospital off-site for some additional testing. I do not know the results of the tests they performed, however, because they never shared them with me. They also said they will need to repeat the test but they have not done it yet.
5. Currently, my baby is not eating. She was not always like this. Before we were detained, she was a healthy baby and ate often. She no longer wants to eat. I breast-feed her because she does not want to eat anything.

GEO AND ICE ARE FAILING TO PROTECT US FROM COVID-19

6. On top of her health complications we worry that our baby is at an increased risk of contracting COVID-19. Because her health has deteriorated in detention, and she's not sleeping or eating, she could very easily get sick. On top of her existing health problems, COVID-19 could really harm her.
7. On top of that, neither GEO or ICE are taking the measures necessary to protect us. In fact, they are exposing us to more risk. My husband, for example, helps clean common areas at Karnes but GEO only provides him with gloves, no masks or hand sanitizer. There is also no hand sanitizer in our rooms or in common areas. When we go eat, hundreds of people, about 200, eat at a time in addition to standing in line much closer than 6 feet away from one another. This is in direct violation of recommended protocols set forth by the US government to fight the spread of COVID-19.
8. GEO guards themselves also expose us to harm. Most do not wear any gloves or masks when in close contact with us. We are afraid that a GEO or ICE officer will bring COVID-19 in with them and we all get sick. They put our health in danger every day.
9. In addition to exposing us to increased risk, there are not poster or notices on the walls in Haitian Creole for us to know how to protect ourselves. The lack of education and information regarding the virus suggest to me that they do not care about our health.
10. We want to be released from detention as soon as possible. Our baby's health continues to deteriorate and doctors have left us in the dark regarding her care. In addition, we are afraid that her poor health puts her in danger of contracting COVID-19. On top of GEO and ICE's failures in protecting our health, we believe that our lives and our children's lives remain in danger the longer we stay here.

Declaration of Ronald Jay Waldman, MD

1. I, Ronald Jay Waldman, MD am currently Professor of Global Health at the Milken Institute School of Public Health at George Washington University, Washington, DC. In addition, I serve as President and Chairman of the Board of Directors of Doctors of the World – USA, a 501(c)(3) not-for-profit entity incorporated in the State of New York.
2. I received my medical degree from the University of Geneva, Switzerland in 1975 and a Master of Public Health degree from the Johns Hopkins University, Baltimore, MD in 1979. Subsequently, I United States Public Health Service as a Commissioned Officer and was assigned as a Medical Epidemiologist to the US Centers for Disease Control and Prevention from 1979-200? I was honorably discharged and retired with the rank of Captain (O6). In addition, I have served as a Medical Officer with the World Health Organization, working in the Division of Child and Adolescent Health. I am the founding Director of the Program on Forced Migration and Health at the Mailman School of Public Health of Columbia University, New York, NY.
3. Finally, I have been employed or partially employed by the United States Agency for International Development since 2007 and have worked to provide them and their partner organizations with assistance in the area of pandemic preparedness.
4. COVID-19 is an acute disease of the respiratory tract caused by a novel corona virus designated SARS-CoV-2 that is transmitted from person-to-person via the respiratory route. It was first reported from Hubei Province China in December 2019 and has subsequently encircled the globe, causing severe illness and death in many countries, including the United States of America, where, as of this writing cases have been confirmed in all fifty states. The exact number of cases and deaths is undeterminable, as serological confirmatory testing has been unavailable for surveillance purposes. Most public health authorities are of the opinion that the actual number of cases is far greater.
5. While case counts change daily, and even hourly, as of this writing (March 21) there have been more than 200 cases reported from the State of Texas, prompting the declaration of the first public health emergency in that State in more than 100 years and resulting in the closing of schools, restaurants, bars, and other places of public gathering.
6. While every demographic within the population is susceptible to becoming infecting the with virus that causes COVID-19, certain groups appear to be at higher risk, and thereby more vulnerable, than others. These include the elderly, especially those with underlying chronic conditions, and others with compromised immune systems, including children.

7. There is no specific cure or medical countermeasure for COVID-19. Only non-pharmaceutical interventions are available to slow its spread and to mitigate the serious consequences that result from it. The most important of these is commonly termed “social distancing”. As the term implies, effective social distancing requires individuals (or family units) to keep a certain distance between themselves; the usual recommendation is 6 feet. In order to reduce/eliminate transmission from an infected to an uninfected individual, individuals having more proximate contact with an actual or potentially infected individual should wear appropriate personal protective equipment.
8. In addition, the virus, if excreted from the respiratory tract of an infected individual, can survive on various surfaces for a time varying from hours to days, depending upon the nature of the surface and the viral load.
9. With the preceding in mind, I have reviewed the ICE Guidelines o COVID-19 (<https://www.ice.gov/covid19>, accessed March 21, 2019). While the guidelines appear to have been prepared with reasonable attention to current scientific knowledge, and with a reasonable degree of respect for current US Government policies, they are deficient in a number of areas, and are not necessarily protective of ICE personnel nor of those in their charge, as witness the confirmation of COVID-19 in an ICE officer in Elizabeth, New Jersey, reported on March 19.
10. The Guidelines are inadequate in the following respects:
 - a. No provisions are made for SARS-CoV-2 serologic testing in either ICE personnel or detainees. Without this, no definitive statements can be made about the existence of virus, disease, or disease transmission in ICE facilities.
 - b. Provisions for personal protective equipment to be used in some circumstances call for the use of surgical masks. These are insufficient and the use of N-95 particulate filtering facepiece respirators should be specified. To be sure, these are in short supply throughout the US, but they represent the “gold standard” and any deviation from this standard should be specified as an inadequate measure for the prevention of transmission.
 - c. The guidance contains no provisions for the appropriate, hygienic, cleaning of potentially contaminated surfaces. Lack of discussion of this potentially important means of transmission in the guidelines is a serious shortcoming.
 - d. The guidelines call for the detention of individuals determined to be I particularly vulnerable in groups, rather than as individuals or in family groups. This places an excess number of people at risk of infection and is poor public health practice.
 - e. Although international air travel has been discouraged in most parts of the world during the pandemic, ICE continues to discuss international air travel for detainees as standard policy. The only concession made to the possibility that the US Government might be responsible for exporting SARS-CoV-2 virus to other countries through this practice is that any detainee with a temperature of 100.4 degrees or higher will be immediately referred to a medical provider. The

means by which body temperature would be determined is not specified, and there is no provision made for the follow-up of any contact of a detainee, whether ICE staff of another detainee, determined to have a high temperature, to be confined and/or tested for COVID-19.

11. It is my expert opinion that the policies expressed in the ICE Guidelines for COVID-19 are inadequate and contrary to accepted public health practice being adopted during the current pandemic. Rather than focusing on how to prevent transmission among ICE officers in detention facilities, policies should be developed to transfer detainees to places where proper social distancing can be practiced. In addition, removal of detainees to foreign countries by air travel should be immediately suspended.

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

Prepared in Washington, DC, on March 21, 2019,

Ronald J. Waldman, MD
Ronald Jay Waldman, MD, MPH

Ronald J. Waldman, M.D., M.P.H.

Department of Global Health
Milken Institute School of Public Health
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Date of Birth: March 4, 1946

Place of Birth: New York, New York, USA

EDUCATION

MPH, Johns Hopkins University School of Hygiene and Public Health, 1979
MD, University of Geneva, Switzerland, 1975
BA, University of Rochester, New York, 1967

PROFESSIONAL EXPERIENCE

Professor of Global Health, Department of Global Health, George Washington University School of Public Health and Health Services, July 2012 – present. Co-director, Humanitarian Health Program. Member, Branch Consortium on impact of armed conflict on reproductive, maternal, neonatal, infant and child health and nutrition.

Advisor, Emerging Pandemic Threats Program, United States Agency for International Development, 2012-present. Provide technical input to the Community Pandemic Preparedness Project (CP3), working with the International Federation of Red Cross and Red Crescent Societies to strengthen the ability of eight low-income countries to prevent, detect, and respond to epidemics and outbreaks of diseases of pandemic potential. Provide technical advice to the Predict Project, one of a suite of USAID-funded projects aiming at strengthening countries' abilities in the areas of viral discovery, identification, surveillance, and response.

President, Doctors of the World – USA, 2014-present. Provide leadership and direction to a growing member of a 16 chapter international non-governmental organization working in the areas of emergency response and health sector development.

Global Health Fellows Program, Public Health Institute, Oakland, California, 2007-2012.

Assigned to the Global Health Bureau, Avian and Human Influenza Unit, of the United States Agency for International Development. Led the development and implementation of the Humanitarian Pandemic Preparedness (H2P) initiative, a \$100 million effort to prepare up to 30 countries for an influenza pandemic. Put together a broad partnership (Humanitarian Pandemic Preparedness) consisting of the International Red Cross and Red Crescent Societies, five United Nations Agencies (UNOCHA, WHO, UNHCR, IOM,

and WFP), the US Department of Defense (AFRICOM and PACOM) and a number of non-governmental organizations. The partners worked with host countries toward the development of detailed pandemic preparedness plans intended to mitigate the consequences of a severe pandemic. From May, 2009, the partnership concentrated primarily on response to the H1N1(2009) pandemic.

Subsequently, directed and coordinated an initiative called "Towards a Safer World", an effort to capture the practical lessons learned from the "whole of society" approach taken for pandemic preparedness. This effort looks across 10 sectors at the current state of global disaster preparedness. Principal partners include the UN Secretariat for Influenza Coordination, World Health Organization, World Food Programme, World Tourism Organization, and the Academy for Educational Development (now FHI360).

Haiti Earthquake Relief: In January-February 2010, led the US Government health sector response to the Haiti earthquake, responsible for coordinating the efforts of USAID, the Department of Health and Human Services including the Centers for Disease Control and Prevention, and the Department of Defense.

Pakistan Flood Relief: From September through November 2010 I was assigned to the World Health Organization and the UN Office for the Coordination of Humanitarian Assistance to advise in the management of the emergency response to the floods in Pakistan and served as Senior Health Advisor to the UN Humanitarian Coordinator.

Professor of Clinical Population and Family Health and Professor of Clinical Epidemiology, 2005-2012. See below.

Deputy Director, Center for Global Health and Economic Development, Mailman School of Public Health of Columbia University, 2003-2005.

Responsibilities included the day-to-day management of this joint venture with the Earth Institute of Columbia University. The Center housed the Forced Migration Program (see below), as well as the Access Project, devoted to helping countries apply for and manage grants from the Global Fund for HIV/AIDS, Tuberculosis and Malaria; the MacroHealth Project, an attempt to devolve to national level the processes that were initiated by WHO's Commission on Macroeconomics and Health; and an NGO, FilmAid, that seeks to use the power of film for health education in refugee camps.

A large proportion of my time at the Center was devoted to co-coordinating The Task Force on Child Health and Maternal Health of the UN Millennium Project and serving as a lead author on its report, Who's Got the Power: Transforming Health Systems for Women and Children.

Professor of Clinical Population and Family Health and Director of the Program on Forced Migration and Health, Heilbrunn Center for Population and Family Health, and the Department of Epidemiology, Mailman School of Public Health of Columbia University, New York, NY 1998-2003.

Founded and directed the Program on Forced Migration and Health. Activities included post-graduate education, short-term training, and research. Responsible for establishing a Master of Public Health program with a concentration in public health in conflict-affected

societies, refugee health, health aspects of humanitarian assistance, and post-conflict rehabilitation of health systems.

Tsunami Relief: served as Emergency Coordinator for WHO in Aceh, Indonesia, December 2004-February 2005.

Technical Director, BASICS, Arlington, VA, 1993-1998.

Responsible for the coordination of all technical aspects of the largest international child health project of the United States Agency for International Development. Responsibilities included supervision of about twenty professional personnel working in immunization, diarrheal disease control, malaria control, control of acute respiratory infections, integrated management of the sick child, health care policy formulation and implementation, childhood nutrition, and long-term behavior change of caretakers and health care professionals. BASICS was active in more than twenty countries in Latin America, Africa, and Asia.

Democratic Republic of Congo: Seconded by CDC to serve as infectious diseases advisor for UNHCR, serving Rwandan refugees in N. and S. Kivu Provinces, July-August, 1994.

Coordinator, WHO Global Task Force on Cholera Control, World Health Organization, Division of Diarrheal and Acute Respiratory Disease Control, Geneva, Switzerland, 1991-1993.

Collaborated with WHO Regional Offices and with Member States in activities involving the planning, implementation, and evaluation of cholera control policies. Also responsible for coordination with other United Nations agencies, bilateral donors, and non-governmental organizations. In conjunction with the Division Director, responsible for policy formation, development of activities, procurement of extra-budgetary funding, and implementation of country and regional programs for the control of cholera, dysentery, and other epidemic diarrheal diseases. Coordinated the writing, publication, and distribution of Guidelines for cholera control (World Health Organization, 1993) and Guidelines for the control of epidemics due to *Shigella dysenteriae* type 1 (WHO/CDR/95.4).

Medical Officer, World Health Organization, Division of Epidemiological Surveillance and Health Situation and Trend Analysis, Geneva, Switzerland, 1991-1992.

Responsible for country-oriented activities of the Programme of Intensified Action for Strengthening Epidemiological Capacities of Member States. In conjunction with other WHO programs, including the Expanded Program on Immunization and the Program for the Control of Diarrheal Diseases, served as facilitator in a number of inter-country workshops to improve the ability to use data derived from surveillance systems for improving health policy formulation and program management. At the request of the Emergency Relief Organization (now Health Action in Crises), developed an emergency health monitoring system for highly vulnerable populations of ex-Yugoslavia. Also served as Co-Secretary of the Task Force for Strengthening Epidemiological Capacities of the Children's Vaccine Initiative and as acting coordinator of the WHO Global Task Force on Cholera Control.

Director, Division of Technical Support, and Assistant Director for Project Development, International Health Program Office, Centers for Disease Control and Prevention, Atlanta, Georgia, 1987-1991.

Responsible for supervising approximately twenty biomedical and social science professionals in international child survival activities including immunization, diarrheal disease control, malaria control, and the control of acute respiratory infections. Disciplines represented in the Division included epidemiology, health education, evaluation research, training, anthropology, and health economics. The Division provided technical assistance in these areas to other parts of CDC, other US government agencies, the World Health Organization, Ministries of Health of foreign governments, and private voluntary organizations. Most of the work by the Division was in support of the USAID-funded Combating Childhood Communicable Diseases project (CCCD).

N. Iraq, displacement of Kurdish population: In 1991, in conjunction the military activity Operation Provide Comfort, coordinated public health services on behalf of USAID.

Coordinator of Diarrheal Disease Control Activities, Centers for Disease Control, International Health Program Office, Atlanta, Georgia, 1985-1987.

Field Epidemiologist, Centers for Disease Control, International Health Program Office, Atlanta, GA, 1983-1985.

Served as consultant (based in Abidjan, Cote d'Ivoire) in sixteen West African countries on health information systems, operational research, and EPI and CDD program planning, implementation and evaluation. Conducted surveys on various aspects of EPI, CDD, and malaria control programs, including childhood mortality and morbidity, use of health service, and prevailing health practices.

Staff Epidemiologist, Centers for Disease Control, International Health Program Office, GA, 1983-1985.

Made multiple visits to African countries to review aspects of public health interventions aimed at reducing infant and child mortality. Worked closely with officials of USAID to develop bilateral health care projects and to negotiate projects in Togo, Liberia, Guinea, and Cote d'Ivoire.

Assisted with the formation of, and was subsequently assigned to, the Refugee Health Unit, Ministry of Health, Somali Democratic Republic as epidemiology consultant (resident, and multiple visits, 1980-1985). Conducted baseline mortality, morbidity and nutrition surveys aimed at establishing priorities for intervention; provided technical support and direction to a large (1,000,000 population) refugee health program, including design and implementation of the surveillance system, training of professional health staff and community health workers, and advising on control of communicable diseases.

Epidemic Intelligence Service (EIS Officer), Centers for Disease Control, Epidemiology Program Office, Atlanta, GA, (assigned to the Michigan Department of Public Health), 1979-1980.

Major projects included two case-control studies that identified aspirin as a major risk factor for the development of Reye Syndrome; investigation and control of outbreaks of acute disseminated histoplasmosis, eastern equine encephalitis, and multiple food-borne outbreaks of various etiologies.

Somalia, refugee relief: was instrumental in describing epidemiological situation of Somali-ethnic Ethiopian refugees throughout Somalia and for designing and implementing appropriate public health interventions. Worked with Ministry of Health and National Refugee Commission to establish Refugee Health Unit and served as senior advisor to it, first in-residence (1979-81) and then periodically (1981-85).

Internship and one year of residency in internal medicine (Board eligible), Highland Hospital, Rochester, NY, 1976-1978.

Medical Epidemiologist, World Health Organization, Smallpox Eradication Program, Geneva, Switzerland, 1975-1976.

Assigned to two rural areas, later to four urban areas, of Bangladesh. Responsibilities included surveillance, detection of cases of smallpox, containment and control, eventually total interruption of transmission within assigned areas, leading to smallpox eradication.

LANGUAGES

French: Fluent speaking, reading, writing

PUBLICATIONS

Colón-Ramos U, Roess AA, Robien K, Marghella PD, Waldman RJ, Merrigan KA. Foods distributed during Federal disaster relief response in Puerto Rico after Hurricane Maria did not fully meet Federal nutrition recommendations. *J Acad Nutr Diet*. 2019 Jun 11.

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Waldman R, Nieburg P. Thoughts on alternative designs for clinical trials for Ebola treatment research. *Am J Bioeth*. 2015;15(4):38-40.

Waldman RJ, Newbrander W. Afghanistan's health system: moving forward in challenging circumstances, 2002-2013. *Glob Public Health*. 2014;;9 Suppl 1:S1-5.

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Brennan R, Waldman RJ. The South Asian Earthquake Six Months Later – an Ongoing Crisis. *New England Journal of Medicine* 2006, Apr 27;354(17):1769-71.

Waldman RJ. Responding to catastrophes: a public health perspective. *Chicago J Intl Law*. 2006; 6:553-79.

Waldman R. The next two issues of *Global Public Health* are devoted to articles related to public health in both natural and man-made emergencies. *Glob Public Health*. 2006;1(2):121-4.

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Grimstad PR, Shabino CL, Calisher CH, Waldman RJ. A case of encephalitis in a human associated with a serologic rise to Jamestown Canyon virus. *Am J Trop Med Hyg* 31:1238-44, November 1982.

Waldman RJ, Hall WN, McGee H, Van Amburg G. Aspirin as a risk factor in Reye's syndrome. *JAMA* 247:3089-94, June 11, 1982.

Blaser MJ, Waldman RJ, Barrett T, Erlandson AL. Outbreaks of *Campylobacter* enteritis in two extended families: evidence for person-to-person transmission. *J Pediatr* 98:254-7, February 1981.

APPOINTMENTS

President, Board of Directors and Executive Committee, Doctors of the World--USA 2014-present

Board of Overseers, International Rescue Committee, 2005-2018

Associate Editor, *Journal of Global Public Health* (peer-review journal), 2005-present

Editorial Board, *Disasters* (peer-review journal), 2003-present

Board of Directors, Physicians for Human Rights, 2004-2010

Health Unit Advisory Board, International Rescue Committee, 2000-present

Associate of the International Health Unit, Burnet Centre for Medical Research and Public Health, Melbourne, Australia, 2000-present

Scientific Advisory Committee, Action Against Hunger, 1999-2003

Co-coordinator, Task Force #4 – Child Health and Maternal Health, UN Millennium Project, 2003-2005

Co-chairman, Global Health Council Annual Conference, "Global Health in Times of Crisis", 2002

Past Chairman, International Health Section, American Public Health Association.

Program Committee, Doctors of the World--USA, 1999-2005.

Roundtable on the Demography of Forced Migration, Committee on Population, National Academy of Sciences, 1999-2005

DECLARATION OF DR. JULIE DEAUN GRAVES

I, Julie DeAun Graves, declare as follows:

1. I am Associate Director of Clinical Services at Nurx, a practicing physician with board certification in Family Medicine, and I am a public health physician, previously serving as Medical Director for the Texas Department of State Health Services for the Houston region, as Medical Services Coordinator for the Texas Department of Aging and Disability Services, and as a medical consultant to the Texas Medical Board. I managed the H1N1 influenza outbreak for the Texas State Supported Living Centers and oversaw public health efforts for the Houston region (population 7 million) for Ebola virus, Zika virus, West Nile virus, highly pathogenic avian influenza, tuberculosis outbreaks, and natural disasters. I obtained my medical degree and completed a surgical internship then family medicine residency at the University of Texas Southwestern Medical School in Dallas, Texas. I earned a Master's degree in Public Health and a Doctor of Philosophy in Management, Policy, and Statistics at the University of Texas School of Public Health. I have practiced family medicine and public health since 1989, and in 2018-2019 I was Associate Professor and Vice-Chair for Education at Georgetown University School of Medicine. I attach a copy of my curriculum vitae.
2. COVID-19 is an illness caused by the SARS-CoV-2 virus, which is a coronavirus that was first detected in humans during the outbreak (now a pandemic) we are experiencing now. The Centers for Disease Control and Prevention reports that as of March 18, 2020 at noon, there are 7,038 cases in the United States, with some cases reported in every state in the US, and there are 97 deaths so far. The Texas Department of State Health Services reports 83 cases and two deaths as of March 18, 2020. The U.S. and Texas are in the early stages of the pandemic, and because there has been insufficient testing for cases, the reported cases numbers are low despite the high probability that there are many more infected individuals in the population. Spread is faster and more dangerous when people are in close quarters. People must maintain distance from others of six feet or more to reduce spread of the virus from person to person.
3. People with health conditions such as diabetes, asthma, emphysema, heart disease, kidney disease, pregnancy, cancer, HIV, and autoimmune diseases like lupus and rheumatoid arthritis are at higher risk for severe illness, complications, and death from COVID-19. People over age 60 have higher death rates, but severe cases of illness and deaths are reported in people of all ages. The ratio of cases of COVID-19 to deaths from this illness is much higher than for other contagious diseases like influenza.

4. The SARS-CoV-2 virus damages the lung tissue, which means that even those who recover need prolonged medical care and rehabilitation. They are likely to have permanent disability from loss of lung capacity. The heart itself can be infected, and kidneys and the nervous system can also be impacted and damaged permanently.
5. There is no vaccine and no treatment for COVID-19. We only have prevention as a tool to stop the pandemic. If we don't move people out of congregate settings, most of them plus the staff who work with them will become infected, and many will die or have permanent disability. People must be in small family groups and should distance 6-10 feet from anyone not in their family group. People should not be in large buildings full of many people, and people must practice thorough hand washing. If we don't do these two steps – distancing and hand washing – the pandemic will not end.
6. COVID-19 is transmitted from person to person by breathing in air that contains the droplets they've coughed or the virus they've shed, or by touching a surface with the virus on it, unless there is full personal protective equipment: mask, gloves, gown, plus thorough handwashing before putting on the equipment and after removing it.
7. As Medical Director for the Texas Department of State Health Services Houston region, I collaborated with the Department of Health and Human Services during disease outbreaks among children who were held in facilities in central and south Texas. I am familiar with these facilities and the conditions faced by people held and by those who work there. In August of 2019 I volunteered with a Catholic Charities facility in Laredo, Texas and provided medical care to people just released from detention in Customs and Border Patrol facilities. I observed the ill health, exhaustion, and malnutrition evident in these people. Additionally, because of my work as Medical Services Coordinator for the Texas Department of Aging and Disability Services overseeing health care in the State Supported Living Centers, which are congregate living settings, I am familiar with the risks to residents and staff of any infectious disease, and particularly those with high infectivity, such as this coronavirus SARS-CoV-2.
8. I have read and analyzed the March 18, 2020 Immigration and Customs Enforcement documentation found at <https://www.ice.gov/covid19>. The guidance regarding personal protective equipment is insufficient to maintain the health and safety of the people held and those who work in these facilities. The document states that Immigration and Customs Enforcement follows guidance from the Centers for Disease Control and Prevention regarding masks and other personal protective equipment. The Centers for Disease Control and Prevention guidance includes using bandanas, scarves, and other home-made protection when sufficient masks are not available. Unless every person with any respiratory symptoms and all workers who are in contact with more than one detainee are wearing properly fit-tested N-95 masks, they are not protected from spread of this

coronavirus SARS-CoV-2. Additionally, the Immigration and Customs Enforcement does not discuss the transmission of SARS-CoV-2 on surfaces. This virus can live and be infectious on surfaces for up to 10 days. There is no guidance in the document about use of surface cleaning agents and any strategies for containing spread by touching of surfaces, nor is there mandate for wearing protective gloves.

9. The March 18, 2020 Immigration and Customs Enforcement documentation states that there are no confirmed cases of COVID-19 in Immigration and Customs Enforcement facilities. However, there is no evidence that any testing for this virus has been performed. There cannot be confirmed cases without testing. The risk is very high that there are indeed unconfirmed cases in these facilities, and that detainees are not being provided with appropriate testing. This guidance document notes that new detainees are screened for risk of COVID-19. However, we are now in a pandemic, and all are at risk. Plus, detainees enter an area of risk when they enter a facility. Detainees who meet risk criteria are housed separately from others, but they are not quarantined alone, but instead held in groups. This does not meet quarantine standards. Also, the document notes that symptomatic detainees are transported to medical appointments with only a mask. This is insufficient. The masks should be N-95, and a thorough fit testing must be performed in order for this N-95 to protect others from an ill person's respiratory secretions. No protective equipment to prevent transmission from surfaces is in place. Those detainees who are transported out of the United States by airplane have not been tested for SARS-CoV-19 and are not transported in appropriate personal protective equipment.
10. Proper procedure in Immigration and Customs Enforcement facilities should be that all detainees and staff practice social distancing as delineated by the Centers for Disease Control and Prevention. Only family groups should be in a space that is sealed off from others, and these groups should maintain distance of at least six feet from other persons. All detainees should be informed about safety protocols and proper hand washing procedures and frequency and monitored to ensure that they are following these protocols and procedures.
11. Even if all of the recommendations made by Immigration and Customs Enforcement and that I have provided are followed, the conditions of detention are such that the detained families would still be at high risk. Because this virus is transmitted through droplets, through the air, and on surfaces, and because people who do not have symptoms but are infected transmit the virus to others, even one infected person in a facility, either a detainee or a staff member, can infect the majority of people in the facility. This is worsened by the crowded conditions in the facilities.
12. For the reasons above, in order to contain the unchecked spread of the COVID-19 virus, we must relocate as many people as possible out of institutional settings. This would also

include civil immigration detention centers. If we do not take steps to permit people to practice social distancing in small family units, these institutional centers will become sites of massive numbers of COVID-19 cases placing both people held there as well as those who work there at high risk of infection with the SARS-CoV-2 virus. Based on indications from countries around the world, many will develop COVID-19 illness with seriousness and sequelae ranging from mild illness to permanent disability to death.

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

Executed this 20th day in March 2020, in North Bay Village, Florida.

A handwritten signature in cursive script that reads "Julie DeAun Graves". The signature is written in black ink and is positioned above a horizontal line.

Dr. Julie DeAun Graves

Julie D. Graves, M.D., M.P.H., Ph.D., F.A.A.F.P.

Current positions:

Family medicine and public health physician in private practice

Associate Director of Clinical Services, Nurx

Education:

06/1979 Bachelor of Arts, Rice University, Houston, Texas

Majors: Biology, Health and Physical Education

06/1983 Doctor of Medicine

The University of Texas Southwestern Medical School, Dallas, Texas

12/1992 Master of Public Health

The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas

Concentration: Health Services Organizations

Thesis: Preferences for Perinatal Health Decisions: A Critical Appraisal

12/2011 Doctor of Philosophy

The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas

Division of Management, Policy, and Community Health

Major: Health Policy

Minors: Management, Biostatistics

Dissertation: Analysis of Policy Issues Surrounding the Electronic Medical Record

Medical licensure:

State: Texas

License No: G5110

Initial Date: 08/23/1983

Renewal/Expiration Date: 02/28/2020

State: Wisconsin

License No: 53273

Initial Date: 06/23/2009

Renewal/Expiration Date: 10/31/2021

State: Alabama

License No: 12408

Initial Date: 10/22/1985

Renewal/Expiration Date: 12/31/1986

State: Nebraska

License No: TX-G5110

Initial Date: 07/20/1985

Renewal/Expiration Date: 07/26/1985

State: Florida

License No: ME134326

Initial Date: 10/25/2017

Renewal/Expiration Date: 01/31/2022

State: District of Columbia

License No: MD045899

Initial Date: 02/26/2018

Renewal/Expiration Date: 12/31/2020

State: Maryland

License No: D84791

Initial Date: 02/16/2018

Renewal/Expiration Date: 09/30/2020

Certifications:

American Board of Family Medicine: Certificate Number 1070893973

Date certified: 07/1989

Dates of Re-certification:

Jul 14, 1989 - Jul 13, 1995

Jul 14, 1995 - Jul 12, 2001

Jul 13, 2001 - Aug 01, 2008

Aug 02, 2008 - Apr 09, 2017

Apr 10, 2017 -12/2027

Advanced Cardiac Life Support 5/1983-12/94, 01/1997-12/2001, 01/2003-12/2018

Advanced Trauma Life Support 01/2003-12/2019

Pediatric Advanced Life Support 01/2004-12/2017

Languages Spoken

English – mother tongue

Spanish – basic medical

German – basic

Previous Academic Appointments and Activities

03/2018-03/2019

Vice-Chair for Education, Department of Family Medicine, Georgetown University School of Medicine

05/2017-12/2017

Associate Professor of Epidemiology, University of Medicine and Health Sciences, St. Kitts and Nevis

06/2015-08/2019

Adjunct Associate Professor of Management, Policy, and Community Health, The University of Texas Health Science Center (UTHealth) School of Public Health

Lecturer: PH 3620, Principles and Practice of Public Health

Lecturer: PH 5220, Gender and Leadership

Preceptor: Occupational Medicine Residency program

Dissertation Committee member: PhD student Stella Okoroafor, MD, MPH (in process)

06/2015-05/17

Faculty, Texas Department of State Health Services Preventive Medicine Residency program

Infectious Diseases and Chronic Disease Preventive Lectures Series Coordinator

06/2014

Visiting Faculty, Tanzania Training Center for International Health

03/2013-08/2014

Associate Professor of Behavioral and Clinical Medicine and Public Health, University of Sint Eustatius School of Medicine

Course director: Epidemiology, Medical Ethics, Biostatistics

09/2012-08/2013

Adjunct Assistant Professor of Epidemiology, The University of Texas Health Science Center (UTHealth) School of Public Health

Dissertation Committee Member, DrPH student Christina Socias (completed)

Associate Professor of Behavioral and Clinical Medicine, American University of the Caribbean School of Medicine, Sint Maarten

Course director and principal faculty, Medical Ethics

Faculty, Introduction to Clinical Medicine

01/2012-09/2012

Assistant Professor of Family and Community Medicine, The University of Texas Health Science Center at San Antonio, Texas

06/2009-08/2009

Graduate Teaching Assistant, The University of Texas Health Science Center (UTHealth) School of Public Health

PH 3620 Principles and Practice of Public Health (on-line course)

11/2002-05/2005

Faculty physician, Austin Medical Education Programs, Family Medicine residency program, Austin, Texas

01/1995-12/1999

Clinical Assistant Professor of Family Medicine, Texas A&M University Brazos Valley Family Medicine residency program, College Station, Texas

11/1992-05/1995

Clinical Assistant Professor of Family Medicine, Baylor College of Medicine, Houston, Texas

Obstetrics fellowship co-coordinator

08/1989-08/1991

Assistant Professor of Family and Community Medicine, The University of Texas Houston Health Science Center

Founding course director, Family Medicine Clinical Clerkship

Co-author, HRSA Primary care training grant

Research Activities

01/2012-09/2012

ReACH Scholar, Center for Research to Advance Community Health, University of Texas Health Science Center at San Antonio

Project: Quality assurance using electronic health records

Principle Investigator: Barbara J. Turner, MD, MSED, MSCP

Internal funding.

01/2007-12/-2009

Research Associate, Health Policy Institute, University of Texas School of Public Health

Projects: Translational research applications of public policy analysis; Food oases

Principle investigators: Stephen Linder, PhD and Eduardo Sanchez, MD, MPH

Internal funding

01/1991-12/1992

Research Associate, Center for Health Policy Studies, University of Texas School of Public Health

Project: Health manpower analysis for primary care in Texas

Principle investigators: Virginia Kennedy, PhD and Frank Moore, PhD

Funding: Texas Higher Education Coordinating Board

08/1989-08/1991

Project staff, University of Texas Houston Health Science Center

Project: Cholesterol reduction with high rice fiber diets

Principle investigator: Mark E. Clasen, MD, PhD

Funding: National Rice Council

09/1988-06/1989

Principle investigator, McLennan County Medical Education and Research Foundation

Project: Obstetrical Practice by Texas Family Physicians

Funding: Texas Higher Education Coordinating Board

Governmental Public Health Practice

06/2017-3/2019

Consultant to Ministry of Health, St. Kitts and Nevis, for disaster preparedness and cannabis health effects

02/2015-05/2017

Regional Medical Director, Texas Department of State Health Services, Health Services Region 6/5S (Houston area, population 7 million)

01/2009-12/2011

Medical consultant, Texas Medicaid Office of Inspector General, Austin, Texas

01/2005-12/2012

Quality monitor and investigator, Texas Medical Board, Austin, Texas

09/2009-05/2011

Medical Services Coordinator for State Supported Living Centers, Texas Department of Aging and Disability Services, Texas (statewide)

Member, Institutional Review Board

05/2001-22/2002

Medical Consultant, Texas Department of Health, Children's Health and Infectious Disease Epidemiology and Surveillance, Austin, Texas (statewide)

Chair, Institutional Review Board, Texas Department of Health

06/1995-12/1999

Educational consultant, Texas WIC (Women, Infants, and Children) nutrition program

01/1994-12/1995

Utilization Review Physician, Lone Star Texas Medicaid managed care program

Clinical Experience

04/2005-02/2015 and 06/2017 – 3/2018

Private practice of family, hospitalist, and emergency medicine, Texas, Sint Maarten, Croatia, Carnival Cruises

09/2005 - 11/2005

Emergency Room Physician, U.S. Army MEDDAC, Wuerzburg, Germany Combat Support Hospital

01/2000-12/2001

Medical Director, Mother's Milk Bank at Austin (volunteer, co-founder)

09/1991-08/1992

Family physician, University of Houston student health service

09/1988-06/1989

Fellowship in Faculty Development, McClellan County Medical Education Research Foundation, Waco, Texas

06/1986-09/1988

Residency in Family Medicine, St. Paul Medical Center, Dallas, Texas

06/1985-05/1986

Locum tenens primary care and emergency medicine physician, CompHealth, Inc., Florida, Alabama, Nebraska, Texas

07/1984-05/1985

Residency training in Anesthesiology, University of Florida Shands Hospital, Gainesville, Florida

07/1983-06/1984

Internship in General Surgery, Parkland Memorial Hospital, Dallas, Texas

Private Sector

01/2009-12/2012

Principal, InGenius Strategies, LLC (health information technology consulting)

01/2005-12/2009

Consultant, Texas Medical Foundation Health Quality Institute (Medicare Quality Improvement Organization for Texas)

05/2005-08/2009

Chief Medical Officer, Practice IT, LLC (health information technology vendor)

01/1995-12/1996

Public policy advocacy, Texas Tobacco Education Project

Honors and Awards:

Outstanding Faculty, Texas Department of State Health Services Preventive Medicine Residency, 06/2017

Team Spirit Award, Texas Department of Health, 11/2002

C. Frank Webber Award for Excellence in Oncology, M.D. Anderson Cancer Center and the Texas Academy of Family Physicians, 05/1998

Fellow of the American Academy of Family Physicians, granted 09/1996

Bibliography

Textbook chapters

1. **Moy, Julie Graves.** “Cardiac Arrest”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
2. **Moy, Julie Graves.** “Advanced Trauma Life Support”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
3. **Moy, Julie Graves.** “Domestic Violence”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
4. **Moy, Julie Graves.** “The Limping Child”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
5. **Moy, Julie Graves.** “Sickle Cell Anemia”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
6. **Moy, Julie Graves.** “Lymphomas and Leukemias”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
7. **Moy, Julie Graves.** “Common Problems in the Newborn”, in Swanson’s Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.
8. **Moy, Julie Graves, Pfenninger, John.** “Peripheral Nerve Blocks and Field Blocks,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994, 2002.
9. **Moy, Julie Graves.** “Induction of Labor,” in Rakel RE. Conn’s Current Therapy. WB Saunders, 1997.
10. **Moy, Julie Graves.** “Development of Clinical Guidelines,” in Mengel M, Fields S (eds.). Guide to Clinical Expertise. New York: Plenum Press, 1996.
11. **Moy, Julie Graves.** “Bites and Stings,” in Taylor RB (ed.). Family Medicine: Principles and Practice. New York: Springer-Verlag, 1994.
12. **Moy, Julie Graves.** “Nasogastric Tube and Salem Sump Insertion,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994.
13. **Moy, Julie Graves.** “Informed Consent,” in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri, Mosby, 1994.
14. Duiker SS, **Moy, Julie Graves.** “Dyspareunia,” in Griffith HW, Dambro M (eds.). The Five-Minute Clinical Consult. Philadelphia: Lea and Febiger, 1993 – 1997.

15. **Moy, Julie Graves**, Duiker, SS. “Sexual Dysfunction in Women”, in Griffith HW, Dambro M (eds.). *The Five-Minute Clinical Consult*. Philadelphia: Lea and Febiger, 1993, 1994, 1995.

16. Duiker SS, **Moy, Julie Graves**. “Community Intervention Strategies in Preventive Cardiology,” in Fuentes F (ed.). *Preventive Cardiology Computer Modules*, Houston: University of Texas Houston Health Science Center, 1991.

Peer-reviewed publications

1. Nguyen DT, Teeter LD, **Graves J**, Graviss EA. Characteristics Associated with Negative Interferon- γ Release Assay Results in Culture-Confirmed Tuberculosis Patients, Texas, USA, 2013–2015. *Emerging Infectious Diseases*. Volume 24, Number 3—March 2018.

2. Liu EL, Morshedi B, Miller BL, Isaacs SM, Fowler RL, Chung W, Blum R, Ward B, Carlo J, Hennes H, Webseter F, Perl T, Noah C, Monaghan R, Tran AH, Benitez F, **Graves J**, Kibbey C, Kelin KR, Swinton RE. Dallas MegaShelter Medical Operations Response to Hurricane Harvey. *Disaster Medicine and Public Health Preparedness*. 2017 Dec 6:1-4.

3. Wiseman R, Weil L, Lozano C, Johnson T, Jin S, Moorman AC, Foster MA, Mixcon-Hayden T, Khudyahov Y, Kuhar DT, **Graves JG**. Healthcare-associated Hepatitis A Outbreak, Texas, 2015. *MMWR*, April 29, 2016 / 65(16);425–426.

4. Socias C, Liang Y, Delclos G, **Graves J**, Hendrickson E, Cooper S. The Feasibility of Using Electronic Health Records to Describe Demographic and Clinical Indicators of Migrant and Seasonal Farmworkers. *Journal of Agromedicine*, 21:71-81, 2016.

5. **Moy, Julie Graves**. Texas State-wide Health Information Technology Policy in 2007: Regional and constituency-specific initiatives move forward, but risk failure without coordination and funding from state government. *Texas Medicine* 105(1):55-63, 2009.

6. **Moy, Julie Graves**. Spirometry in Urgent Care. *Urgent Care*, May 2007.

7. Holleman W, Holleman MC, **Moy, Julie Graves**. Continuity of Care and Ethics in Managed Care. *Archives of Family Medicine*, 1999;8.

8. Mullen PD, Pollack KI, Titus JP, Sockrider MM, **Moy, Julie Graves**. Smoking Cessation Practices of Texas Obstetricians. *Birth*, 1998; 25:25-30.

9. Roberts R, Bell H, Wall E, **Moy, Julie Graves**, Hess G, Bower G. Trial of Labor or Repeat Caesarean Section: The Woman’s Choice. *Archives of Family Medicine*. 1997;6:120-125.

10. Holleman W, Holleman MC, **Moy, Julie Graves**. Managed Care and Ethics: A Match Made in Heaven or Strange Bedfellows? *The Lancet* 1997; February 8.

11. **Moy, Julie Graves**, Realini JP. Guidelines for Preventive Therapy with Estrogen and Progesterone for Postmenopausal Women. *Journal of the American Board of Family Practice* 1993;6:153-162.

12. Berg AO, **Moy, Julie Graves**. Policy Review: Guidelines for the Diagnosis and Treatment of Asthma. *Journal of the American Board of Family Practice* 1992;5:629-634.

13. **Moy, Julie Graves**, Clasen ME. The Patient with Gonococcal Infection. *Primary Care* 1990;17:59-83.

14. **McCraney, Julie Graves**. The Status of Obstetrical Practice by Texas Family Physicians. *Texas Medicine* 1989;86:53-6.

Monographs, non-refereed publications, government reports, and published abstracts

1. **Moy, Julie Graves**, Sanchez E. Food Oases: A White Paper. University of Texas School of Public Health Institute for Health Policy. May 2008.

2. **Moy, Julie Graves**. Texas End-of-Life Care Law. Texas Medical Association, 2005.

3. Kaye CI, Cody JD, Canfield M, Martinez J, Van de Putte L, **Moy, Julie Graves**, Borg M, Stanley S, Wang J, Visio P. The Development of the Texas State Genetics Plan and a Plan for Integrated Data Infrastructure for Genetic Service. University of Texas Health Science Center at San Antonio and Texas Department of Health, 2002

4. **Moy, Julie Graves**. Medical Ethics and Professionalism. Texas Medical Association, February 1999, updated 2004.

5. **Moy, Julie Graves**. Family Physicians on the Internet. *Texas Family Physician* 1996, January/February.

6. **Moy, Julie Graves**. Catastrophe Theory and Chaos: A Means to Understand What Happens in the Clinical Setting. North American Primary Care Research Group Annual Meeting, San Diego, California, November 1993. Abstract.

7. Grimes R, Brimlow D, **Moy, Julie Graves**. HIV/AIDS Interdisciplinary Clinical Preceptorships: Design, Implementation, and Evaluation. American Public Health Association, 1991. Abstract.

8. Grimes R, **Moy, Julie Graves**. Clinical Mini-Residency for Primary Care Medical School Faculty. AIDS Education and Training Centers Annual Meeting, San Francisco, California, December 14, 1991.

9. **Moy, Julie Graves**, Fowler GC. Sexually Transmitted Disease. Home Study Self-Assessment Program, number 149. American Academy of Family Physicians, October 1991.

10. **Moy, Julie Graves**. Impact of Medicare Reform upon Family Medicine Research. *Society of Teachers of Family Medicine Research News* 1990;3:1-3.

11. **McCraney, Julie Graves**. The Role of the Family Physician in the Management of Breastfeeding. *Texas Family Physician* 1989, May/June.

12. **McCraney, Julie Graves.** The Resource-Based Relative Value Scale. Texas Family Physician 1989, March/April.

13. **McCraney, Julie Graves.** A Resident Considers AIDS. Texas Family Physician 1988, May/June.

Letters to the Editor

1. **Moy, Julie Graves.** Flu Season Offers Opportunities to Keep Patients Healthy and out of the Hospital. Travis County Medical Association Journal, 2003; 49:18-19.

2. **Moy, Julie Graves.** Putting babies “back to sleep”. Journal of the American Medical Association. 1999 March 17:281 (11): 983.

3. **Moy, Julie Graves,** Rourke J. Physician’s Breastfeeding Course in Texas. Academy of Breastfeeding Medicine News and Views 1996:2(1).

4. **Moy, Julie Graves.** Who Practices in the ER? Health Affairs. March 2008 27:2w84-w95.

Service on State and National Panels and Committees:

Health Policy Panel Membership

1. Texas Department of Health Panel on Infant Feeding (co-author, Texas Department of Health Position Statement on Infant Feeding) 1997

2. National Heritage Insurance Company Medical Affairs Committee on Pilot Managed Care Program for Texas Medicaid Program 1994

3. National Institutes of Health Consensus Panel on Treatment of Cervical Dysplasia, Bethesda System Classification Development Team (Report published in the Journal of the American Medical Association 1994: 271, Kurman et al.) 1994

4. Rand Corporation / Health Care Financing Administration Medicaid Necessity, Outcomes, and Appropriateness Study on Pediatric Asthma 1992

5. Texas Department of Human Services Physician Payment Advisory Committee 1990

6. March of Dimes National Committee on Perinatal Health (co-author, Toward Improving the Outcomes of Pregnancy, monograph published by March of Dimes, 1993)

7. Texas Department of Human Services Indigent Care Advisory Committee 1989

Policy Reviews for American Academy of Family Physicians Task Force on Clinical Policies 1990-94

1. Agency for Health Care Policy and Research Pressure Sore Panel
2. National Heart, Lung, and Blood Institute Panel on Treatment of Asthma During Pregnancy and Lactation
3. National Heart, Lung, and Blood Institute Guidelines for the Diagnosis and Treatment of Asthma
4. American Academy of Ophthalmology Policy on Strabismus
5. Expert Panel on Preventive Services paper on Iron Supplementation During Pregnancy
6. Expert Panel on Preventive Services paper on Testing for D Isoimmunization in Pregnancy
7. American Academy of Pediatrics practice parameter on Treatment of Acute Asthma Exacerbation in Children
8. American Academy of Pediatrics practice parameter on Hyperbilirubinemia in the Newborn Service on Medical School Committees:

Member, Practice Council, The University of Texas Health Science Center (UTHealth) School of Public Health at Houston, 2014 -present

Member, Council on Education for Public Health (CEPH) Expanded Steering Committee, The University of Texas Health Science Center (UTHealth) School of Public Health at Houston, 2016.

Member, Curriculum Committee, The University of Texas Health Science Center Medical School, 1990

Vice-chair, Institutional Review Board, University of Medicine and Health Sciences, St. Kitts and Nevis, 2017

Editorial Review for Medical Journals:

2018-present Peer Reviewer, American Family Physician

2017-present Peer Reviewer, Texas Public Health Association Journal

2001-2016 Peer Reviewer, Journal of Family Practice

2010-2017 Peer Reviewer, Family Practice Management

1997 Peer Reviewer, Feminist Economics

1995-1998 Editorial Review Board, Journal of Human Lactation
1994-1997 Peer Reviewer, American Family Physician
1993-2013 Peer Reviewer, Texas Medicine
1992-1997 Peer Reviewer, Archives of Family Medicine
1992-1995 Peer Reviewer, Family Medicine
1990-1993 Editorial Committee, Texas Medicine
1988-1989 Editor, Texas Family Physician "Resident Forum"

Presentations at Scientific Meetings:

1. Garrison R, **Graves J.** An Analysis of Barriers to Care for Patients Requiring Rabies Post-exposure Prophylaxis in Texas Department of State Health Services Region 6/5S. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas
2. Ramsey J, Mayes B, **Graves J.** Demographics of Child Fatality in Rural Southeast Texas. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas (poster)
3. Jones R, Abrego D, Deeba R, Varghese C, LaBar C, Mayes B, **Graves J.** Public Health Prevention Needs for Domestic Minor Sex Trafficking in Rural Southeast Texas Counties. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas
4. **Graves J.** Vector-borne Disease Public Policy. South Texas Tropical Medicine and Vector Borne Disease conference. February 24, 2017. South Padre Island, Texas
5. Martinez D, Jin S, Milligan S, Haynie A, Arenare B, Wiseman R, Weil L, Lozano C, Johnson T, **Graves J.** Investigation of a healthcare associated Hepatitis A cluster in and nearby Harris County, Texas. Council of State and Territorial Epidemiologists Annual Meeting. June 2017. Anchorage Alaska (poster).
6. Lin H, Weil L, Evans D, Shaw D, Rosen G, **Graves J.** Regional Epidemiology Coordination Plan: effective use during a multijurisdictional outbreak investigation. Texas Public Health Association 92nd Annual Education Conference, April 2016, Galveston, Texas
7. Rosen G, Lin H, Swanson K, Shaw D, Weil L, Evans D, **Graves J.** Local challenges to state policy: Evaluating the interim guidance for monitoring and movement of persons with potential Ebola Virus exposure in Southeast Texas --October-December, 2014. American Public Health Association Annual Meeting, October 2015, Chicago, Illinois.

8. **Graves J.** Health Information Technology Policy in Germany, Switzerland, and Austria: Lessons for US Policy Makers. American Public Health Association Annual Meeting, San Diego, California, October 2012
9. **Graves J, Sanchez E.** Meeting the Health Needs of the Emerging Majority: Applying Lessons Learned from Border Health Programs to Eliminate Health Disparities throughout the U.S. American Public Health Association Annual Meeting, San Diego, California, October 2008
10. **Graves J, Aday L.** Decision Analysis and Preferences for Perinatal Health States. Agency for Health Care Policy and Research Third Primary Care Conference. Atlanta, Georgia, January 1993
11. **Moy, Julie Graves, Susman J, Berg A.** Critiquing Clinical Policies. Society of Teachers of Family Medicine Annual Meeting, San Diego, California, April 1993
12. **Moy, Julie Graves, Schindler J, Duiker SS.** Teaching Ambulatory Care in the Urban Setting, American Association of Medical Colleges Southern Group for Educational Affairs, Houston, Texas, April 1991
13. **Moy, Julie Graves, Clasen ME, Donnelly J.** Implementation of a Required Third year Clerkship in Family Medicine after Legislative Directive. Society of Teachers of Family Medicine Predoctoral Education Conference, San Antonio, Texas, February 1991.
14. **Moy, Julie Graves, Goertz R.** Legislative Directive for a Third year Family Medicine Clerkship. Society of Teachers of Family Medicine, Seattle Washington, May 1990.
15. **Conard S, Dahms L, McCraney, Julie Graves.** Stress in Residency: External Causes, Manifestations, and Impairment in Family Medicine as Compared to Other Specialties. Texas Academy of Family Physicians, Austin, Texas, September 1988, first place; also at American Academy of Family Physicians, Los Angeles, October 1988.

Invited Lectures

1. The US Health Care System in Transition. University of Medicine and Health Sciences Health Policy Lecture Series. July 13, 2017. Basseterre, St. Kitts and Nevis.
2. Legislative Issues Regarding Syndromic Surveillance. Texas Health Information Management Systems Society Legislative Conference. April 12, 2017, Austin, Texas.
3. Cross-Jurisdictional Coordination for Super Bowl LI Planning. Local Health Authorities Symposium. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas
4. Texas Syndromic Surveillance System. Health Information Management Systems Society, Austin Chapter, August 9, 2016
5. A Congressional Forum on the Zika Virus and a Discussion of an Action Plan for Houston and Harris County. Good Neighbor Health Clinic, Houston, March 10, 2016.

6. Telemedicine for Children with Special Health Care Needs. Caring for Children with Special Health Care Needs in Medicaid Managed Care, Texas Health and Human Services Commission, Austin, Texas, March 8, 2002. With Nora Taylor Belcher
7. Medicaid and Managed Care. Women in Government Forum on Medicaid, Austin, Texas, September 16, 1995.
8. Managed Care and Managed Competition. Southeast Texas Chapter of the International Patient Education Council, University of Texas MD Anderson Cancer Center, June 2, 1993.
9. AIDS and Adolescents: HIV Policy Concerns. National Conference of State Legislatures Women's Network, Mobile, Alabama, May 20, 1993.
10. Vaginal Birth after Cesarean. Visiting Professor in Perinatal Health, University of Kansas School of Medicine Perinatal Conference, Kansas City, Kansas, April 3, 1992.
11. The Development of Medical Specialties in America. History of Medicine Lectures, University of Texas Houston Health Science Center, April 25, 1991.

Presentations at Professional Development Courses

1. Analysis of Policy Issues Surrounding the Electronic Medical Record. Grand Rounds. University of Texas Health Science Center at San Antonio. October 14, 2011. One hour Category I credit.
2. Barriers to Preventive Care for Women with Disabilities. Center for Health Disparities Annual Conference, University of North Texas Health Science Center, Ft. Worth, Texas, May 8, 2010. One hour Category I credit.
3. Clinical Indicators in Medicare's Hospital Quality Improvement Project. Houston, Texas. January 13, 2006. One hour Category I credit.
4. Recent Changes to Texas End-of-Life Care Law. St. David's Medical Center, Austin, Texas. October 12, 2004. One hour Category I credit, one hour Texas Ethics credit.
5. Aggressive Treatment of Type II Diabetes: What's New in Type II Diabetes and Improving Chronic Disease Management Care with a Systems Approach. Texas Academy of Family Physicians. El Paso, Texas, May 2002. Two hours Category I credit.
6. Update in Medical Ethics and Professionalism. Central Texas Continuing Education Consortium. Austin, Texas, October 1999. One hour Category I credit.
7. Breastfeeding Update. Grand Rounds. Columbia Bayshore Medical Center, Pasadena, Texas, July 16, 1998. One hour Category I credit.
8. Breastfeeding in Special Circumstances. American Academy of Family Physicians Annual Session September 17, 1997, Chicago IL, 1 hour prescribed credit. Taught again in Annual Session in 1998.

9. Breastfeeding Update. Presbyterian Hospital Combined Obstetrics/Pediatrics conference, April 1997, 1 hour AMA Category I credit.
10. Intensive Course in Breastfeeding: Lactation Management Workshop for Physicians. April 24, 1996, Houston, Texas. Four hours AAFP credit. Taught again Harlingen, Texas; Tyler, Texas; San Antonio, Texas, Dallas, Texas, Sugar Land, Texas in 1996, 1997, with Linda Zeccola, Tom Hale, Joanie Fischer, and Maryelle Van Landen
11. Intensive Course in Breastfeeding. March 11, 1996, Midland, Texas. Four hours continuing nursing education credit. Taught again in Gallup, New Mexico and Boise, Idaho.
12. Breastfeeding: Improving the Support System. Hermann Hospital/UT Houston Medical School Annual Perinatal Conference, Houston, Texas June 1996, 1 hour AMA credit.
13. Breastfeeding Update. Women's Hospital, Houston, Texas, September 1996, 1 hour AMA Category I.
14. Breastfeeding: Enlightening the Myths. Abilene Perinatal Conference, October 1996, 1 hour AMA Category I credit.
15. Family Oriented Prenatal Care. Baylor College of Medicine Advances in Family Medicine. January 20, 1995. 1/2 hour prescribed credit.
16. American Academy of Family Physicians Clinical Policies Training Course. San Diego, California, April 1993. 9.5 hours prescribed credit, with Hanan Bell
17. Preference/ Utility Assessment in Outcomes Research. Agency for Health Care Policy and Research Third Primary Care Conference, Atlanta, Georgia, January 10, 1993. 1 hour prescribed credit.
18. Hormone Replacement Therapy. Clinical Recommendations Update at American Academy of Family Physicians Scientific Assembly, Orlando Florida, October 1993. 2 hours prescribed credit.
19. Problems and Solutions in Integrating Clerkship Teaching with Residency Education. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, May 18, 1990. 1 hour prescribed credit, with Donald Koester
20. The Status of Obstetrical Practice by Texas Family Physicians: Implications for Residency Training. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, February, 1989. 1 hour prescribed credit.
21. The Genogram in Prevention. University of Texas Houston Health Science Center/ Texas Academy of Family Physicians Prevention for the Nineties Conference, Houston, Texas, October 30, 1989. 1 hour prescribed.

Professional Organizations:

American Public Health Association 1992-present

2020-2023 Governing Councilor
2015-2016 Joint Policy Committee member; Co-chair, 2016
2016 Executive Board member, *ex officio*
2014-2017 Submission Review for Annual Scientific Meeting
2012-2016 Science Board member; Chair, 2016
Medical Care Section (Mentoring Chair 2018)
International Health Section

Florida Public Health Association 2019-present

Florida Medical Association 2019-present

Travis County Medical Society 1995-2014

1998-2001 Committee on Legislation; Chair 1999-2000
1996-1999 Alternate Delegate to Texas Medical Association

Harris County Medical Society 1989-1995 and 2015-2016

2015-2016 Committee on Communication and Public Health
2015-2016 Emergency Care Committee, *ex officio*
1995 Delegate to Texas Medical Association
1994-1995 Board of Medical Legislation
1990-1995 Committee on Membership and Medical Precepts
1992-1993 Executive Board, Central Branch
1991-1994 Alternate Delegate to Texas Medical Association
1991 Medical Student Committee
1991 Chair, Young Physicians Section
2015–present Committee on Communications and Public Health

Texas Medical Association 1987-2016

1995-2001 TexPAC (political action committee) Board of Directors
1994 Task Force on Hospital Staff-County Medical Society Relations
1993-1994 *ad hoc* Committee on Practice Parameters
1998 Council on Public Health
1991-1992 *ad hoc* Committee on International Medical Graduate Issues
1990-1994 TexPAC (political action committee) Vice-chairman
1990-1991 Young Physicians Governing Council
1989 Chairman, McLennan County MediCaring Task Force
1989-1991 Committee on Manpower
1989 Council on Socioeconomics
1987-1988 Committee on Health Insurance

American Medical Association 1987-1999, 2006-2008, 2010 -2011

1991 Executive Committee and Founding Member, Women's Caucus
1989-1994 Medical Schools Section, Delegate for University of Texas Health Science Center,
Houston

American Academy of Family Physicians 1987-present

- 1993-1999 Peer Reviewer, Home Study/Self-Assessment Program
- 1991-1995 Task Force on Clinical Policies for Patient Care; Executive Committee
- 1993-1994 Vaginal Birth after Caesarean Section Policy Team

Texas Academy of Family Physicians 1987-2016

- 1997 -1998 Task Force on Governance
- 1997 Task Force on Computers
- 1996 Task Force on Health System Reform
- 1997 Committee on Public Health and Scientific Affairs Chairman, 1995-1997
- 1994-1996 Committee on Legislation and Public Policy Vice-chair, 1996
- 1990 Vice-Chairman, Student Affairs Committee

Names used due to marriage:

- Julie Graves 1957-1984 and 2012 - present
- Julie Graves McCraney 1984 - 1999
- Julie Graves Moy 1999 – 2012

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Josiah “Jody” Rich, MD, MPH
Professor of Medicine and Epidemiology, Brown University
Director of the Center for Prisoner Health and Human Rights
Attending Physician, The Miriam Hospital,
164 Summit Ave.
Providence, RI 02906

March 19, 2020

The Honorable Bennie Thompson
Chairman
House Committee on Homeland Security
310 Cannon House Office Building
Washington, D.C. 20515

The Honorable Ron Johnson
Chairman
Senate Committee on Homeland Security
and Governmental Affairs
340 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Rogers
Ranking Member
House Committee on Homeland Security
310 Cannon House Office Building
Washington, D.C. 20515

The Honorable Gary Peters
Ranking Member
Senate Committee on Homeland Security
and Governmental Affairs
340 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Carolyn Maloney
Chairwoman
House Committee on Oversight and Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Jim Jordan
Ranking Member
House Committee on Oversight and Reform
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Committee Chairpersons and Ranking Members:

We are physicians—an internist and an infectious disease specialist—with unique expertise in medical care in detention settings.¹ We currently serve as medical subject matter experts for the

¹ I, Dr. Scott Allen, MD, FACP, am a Professor Emeritus of Medicine, a former Associate Dean of Academic Affairs and former Chair of the Department of Internal Medicine at the University of California Riverside School of Medicine. From 1997 to 2004, I was a full-time correctional physician for the Rhode Island Department of Corrections; for the final three years, I served as the State Medical Program. I have published over 25 peer-reviewed papers in academic journals related to prison health care and am a former Associate Editor of the International Journal of Prisoner Health Care. I am the court appointed monitor for the consent decree in litigation involving

Department of Homeland Security's Office of Civil Rights and Civil Liberties (CRCL). One of us (Dr. Allen) has conducted numerous investigations of immigration detention facilities on CRCL's behalf over the past five years. We both are clinicians and continue to see patients, with one of us (Dr. Rich) currently providing care to coronavirus infected patients in an ICU setting.

As experts in the field of detention health, infectious disease, and public health, we are gravely concerned about the need to implement immediate and effective mitigation strategies to slow the spread of the coronavirus and resulting infections of COVID-19. In recent weeks, attention has rightly turned to the public health response in congregate settings such as nursing homes, college campuses, jails, prisons and immigration detention facilities (clusters have already been identified in Chinese and Iranian prisons according to news reports² and an inmate and an officer have reportedly just tested positive at New York's Rikers Island).³ Reporting in recent days reveals that immigrant detainees at ICE's Aurora facility are in isolation for possible exposure to coronavirus.⁴ And a member of ICE's medical staff at a private detention center in New Jersey has now been reported to have tested positive for coronavirus.⁵

We have shared our concerns about the serious medical risks from specific public health and safety threats associated with immigration detention with CRCL's Officer Cameron Quinn in an initial letter dated February 25, 2020, and a subsequent letter of March 13, 2020. We offered to

medical care at Riverside County Jails. I have consulted on detention health issues both domestically and internationally for the Open Society Institute and the International Committee of the Red Cross, among others. I have worked with the Institute of Medicine on several workshops related to detainee healthcare and serve as a medical advisor to Physicians for Human Rights. I am the co-founder and co-director of the Center for Prisoner Health and Human Rights at Brown University (www.prisonerhealth.org), and a former Co-Investigator of the University of California Criminal Justice and Health Consortium. I am also the founder and medical director of the Access Clinic, a primary care medical home to adults with developmental disabilities.

I, Dr. Josiah (Jody) Rich, MD, MPH, am a Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and a practicing Infectious Disease Specialist since 1994 at The Miriam Hospital Immunology Center providing clinical care for over 22 years, and at the Rhode Island Department of Corrections caring for prisoners with HIV infection and working in the correctional setting doing research. I have published close to 190 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions and incarceration. I am the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital (www.prisonerhealth.org), and a Co-Founder of the nationwide Centers for AIDS Research (CFAR) collaboration in HIV in corrections (CFAR/CHIC) initiative. I am Principal Investigator of three R01 grants and a K24 grant all focused on incarcerated populations. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I have served as an expert for the National Academy of Sciences, the Institute of Medicine and others.

² Erin Mendel, "Coronavirus Outbreaks at China Prisons Spark Worries About Unknown Clusters," *Wall Street Journal*, February 21, 2020, available at: <https://www.wsj.com/articles/coronavirus-outbreaks-at-china-prisons-spark-worries-about-unknown-clusters-11582286150>; Center for Human Rights in Iran, "Grave Concerns for Prisoners in Iran Amid Coronavirus Outbreak," February 28, 2020, available at <https://iranhumanrights.org/2020/02/grave-concerns-for-prisoners-in-iran-amid-coronavirus-outbreak/>.

³ Joseph Konig and Ben Feuerherd, "First Rikers Inmate Tests Positive for Coronavirus" *New York Post*, March 18, 2020, available at: <https://nypost.com/2020/03/18/first-rikers-island-inmate-tests-positive-for-coronavirus/>

⁴ Sam Tabachnik, "Ten detainees at Aurora's ICE detention facility isolated for possible exposure to coronavirus," *The Denver Post*, March 17, 2020, available at <https://www.denverpost.com/2020/03/17/coronavirus-ice-detention-geo-group-aurora-colorado/>.

⁵ Emily Kassie, "First ICE Employees Test Positive for Coronavirus," *The Marshall Project*, March 19, 2020, available at <https://www.themarshallproject.org/2020/03/19/first-ice-employees-test-positive-for-coronavirus>

work with DHS in light of our shared obligation to protect the health, safety, and civil rights of detainees under DHS's care. Additionally, on March 17, 2020 we published an opinion piece in the *Washington Post* warning of the need to act immediately to stem the spread of the coronavirus in jails and prisons in order to protect not only the health of prisoners and corrections workers, but the public at large.⁶

In the piece we noted the parallel risks in immigration detention. We are writing now to formally share our concerns about the imminent risk to the health and safety of immigrant detainees, as well as to the public at large, that is a direct consequence of detaining populations in congregate settings. We also offer to Congress, as we have to CRCL, our support and assistance in addressing the public health challenges that must be confronted as proactively as possible to mitigate the spread of the coronavirus both in, and through, immigration detention and congregate settings.

Nature of the Risk in Immigration Detention and Congregate Settings

One of the risks of detention of immigrants in congregant settings is the rapid spread of infectious diseases. Although much is still unknown, the case-fatality rate (number of infected patients who will die from the disease) and rate of spread for COVID-19 appears to be as high or higher than that for influenza or varicella (chicken pox).

In addition to spread within detention facilities, the **extensive transfer of individuals** (who are often without symptoms) throughout the detention system, which occurs with great frequency in the immigration context, could rapidly disseminate the virus throughout the entire system with devastating consequences to public health.⁷

Anyone can get a coronavirus infection. While healthy children appear to suffer mildly if they contract COVID-19, they still pose risk as carriers of infection, particularly so because they may not display symptoms of illness.⁸ Family detention continues to struggle with managing outbreaks of influenza and varicella.⁹ Notably, seven children who have died in and around

⁶ Josiah Rich, Scott Allen, and Mavis Nimoh, "We must release prisoners to lessen the spread of coronavirus," *Washington Post*, March 17, 2020, available at <https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus/>.

⁷ See Hamed Aleaziz, "A Local Sheriff Said No To More Immigrant Detainees Because of Coronavirus Fears. So ICE Transferred Them All To New Facilities," *BuzzFeed News*, March 18, 2020 (ICE recently transferred 170 immigrant detainees from Wisconsin to facilities in Texas and Illinois. "In order to accommodate various operational demands, ICE routinely transfers detainees within its detention network based on available resources and the needs of the agency...," an ICE official said in a statement.), available at <https://www.buzzfeednews.com/article/hamedaleaziz/wisconsin-sheriff-ice-detainees-coronavirus>

⁸ Interview with Jay C. Butler, MD, Deputy Director for Infectious Diseases, Centers for Disease Control and Prevention, "Coronavirus (COVID-19) Testing," *JAMA Network*, March 16, 2020, available at <https://youtu.be/oGiOi7eV05g> (min 19:00).

⁹ Indeed, I (Dr. Allen) raised concerns to CRCL, the DHS Office of Inspector General, and to Congress in July 2018, along with my colleague Dr. Pamela McPherson, about the risks if harm to immigrant children in family detention centers because of specific systemic weaknesses at those facilities in their ability to provide for the medical and mental health needs of children in detention. See, e.g., July 17, 2018 [Letter to Senate Whistleblower Caucus Chairs](#) from Drs. Scott Allen and Pamela McPherson, available at <https://www.wyden.senate.gov/imo/media/doc/Doctors%20Congressional%20Disclosure%20SWC.pdf>. Those concerns, including but not limited to inadequate medical staffing, a lack of translation services, and the risk of

immigration detention, according to press reports, six died of infectious disease, including three deaths from influenza.¹⁰ Containing the spread of an infection in a congregate facility housing families creates the conditions where many of those infected children who do not manifest symptoms will unavoidably spread the virus to older family members who may be a higher risk of serious illness.

Finally, as you well know, social distancing is essential to slow the spread of the coronavirus to minimize the risk of infection and to try to reduce the number of those needing medical treatment from the already-overwhelmed and inadequately prepared health care providers and facilities. However, social distancing is an oxymoron in congregate settings, which because of the concentration of people in a close area with limited options for creating distance between detainees, are at very high risk for an outbreak of infectious disease. This then creates an enormous public health risk, not only because disease can spread so quickly, but because those who contract COVID-19 with symptoms that require medical intervention will need to be treated at local hospitals, thus increasing the risk of infection to the public at large and overwhelming treatment facilities.

As local hospital systems become overwhelmed by the patient flow from detention center outbreaks, precious health resources will be less available for people in the community. To be more explicit, a detention center with a rapid outbreak could result in multiple detainees—five, ten or more—being sent to the local community hospital where there may only be six or eight ventilators over a very short period. As they fill up and overwhelm the ventilator resources, those ventilators are unavailable when the infection inevitably is carried by staff to the community and are also unavailable for all the usual critical illnesses (heart attacks, trauma, etc). In the alternate scenario where detainees are released from high risk congregate settings, the tinderbox scenario of a large cohort of people getting sick all at once is less likely to occur, and the peak volume of patients hitting the community hospital would level out. In the first scenario, many people from the detention center *and the community* die unnecessarily for want of a ventilator. In the latter, survival is maximized as the local mass outbreak scenario is averted.

It is additionally concerning that dozens of immigration detention centers are in remote areas with limited access to health care facilities. Many facilities, because of the rural locations, have only one on-site medical provider. If that provider gets sick and requires being quarantined for at least fourteen days, the entire facility could be without any medical providers at all during a foreseeable outbreak of a rapidly infectious disease. We simply can't afford a drain on resources/medical personnel from any preventable cases.

communication breakdowns and confusion that results from different lines of authority needing to coordinate between various agencies and partners from different government programs and departments responsible for detention programs with rapid turnover, all continue to contribute to heightened risks to meeting the medical challenges posed by the spread of the coronavirus.

¹⁰ Nicole Acevedo, "Why are children dying in U.S. custody?," *NBC News*, May 29, 2019, available at <https://www.nbcnews.com/news/latino/why-are-migrant-children-dying-u-s-custody-n1010316>

Proactive Approaches Required

Before coronavirus spreads through immigration detention, proactivity is required in three primary areas: 1) Processes for screening, testing, isolation and quarantine; 2) Limiting transport and transfer of immigrant detainees; and 3) Implementing alternatives to detention to facilitate as much social distancing as possible.

Protocols for early screening, testing, isolation and quarantine exist in detention settings to address infectious diseases such as influenza, chicken pox and measles. However, the track record of ICE facilities implementing these protocols historically has been inconsistent. In the current scenario, with widespread reporting about the lack of available tests for COVID-19 and challenges for screening given the late-onset display of symptoms for what is now a community-spread illness, detention facilities, like the rest of country, are already behind the curve for this stage of mitigation.

Detention facilities will need to rapidly identify cases and develop plans to isolate exposed cohorts to limit the spread, as well as transfer ill patients to appropriate facilities. Screening should occur as early as possible after apprehension (including at border holding facilities) to prevent introduction of the virus into detention centers. We strongly recommend ongoing consultation with CDC and public health officials to forge optimal infection prevention and control strategies to mitigate the health risks to detained patient populations and correctional workers. Any outbreak in a facility could rapidly overwhelm the capacity of healthcare programs. Partnerships with local public health agencies, hospitals and clinics, including joint planning exercises and preparedness drills, will be necessary.

Transferring detainees between facilities should be kept to an absolute minimum. The transfer process puts the immigrants being transferred, populations in the new facilities, and personnel all at increased risk of exposure. The nationwide network of detention centers, where frequent and routine inter-facility transfers occur, represents a frighteningly efficient mechanism for rapid spread of the virus to otherwise remote areas of the country where many detention centers are housed.

Finally, regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, ***it is essential to consider releasing all detainees who do not pose an immediate risk to public safety.***

Congregant settings have a high risk of rapid spread of infectious diseases, and wherever possible, public health mitigation efforts involve moving people out of congregate settings (as we are seeing with colleges and universities and K-12 schools).¹¹ Minimally, DHS should consider releasing all detainees in high risk medical groups such as older people and those with

¹¹ Madeline Holcombe, "Some schools closed for coronavirus in US are not going back for the rest of the academic year," *CNN*, March 18, 2020, available at <https://www.cnn.com/2020/03/18/us/coronavirus-schools-not-going-back-year/index.html>; Eric Levenson, Chris Boyette and Janine Mack, "Colleges and universities across the US are canceling in-person classes due to coronavirus," *CNN*, March 12, 2020, available at <https://www.cnn.com/2020/03/09/us/coronavirus-university-college-classes/index.html>.

chronic diseases. COVID-19 infection among these groups will require many to be transferred to local hospitals for intensive medical and ventilator care—highly expensive interventions that may soon be in short supply.

Given the already established risks of adverse health consequences associated with the detention of children and their families,¹² the policy of detention of children and their families in should be reconsidered in light of these new infectious disease threats so that children would only be placed in congregate detention settings when lower risk community settings are not available and then for as brief a time as possible.

In addition, given the low risk of releasing detainees who do not pose a threat to public safety—i.e., those only charged with immigration violations—releasing *all* immigration detainees who do not pose a security risk should be seriously considered in the national effort to stop the spread of the coronavirus.

Similarly, the practice of forcing asylum seekers to remain in Mexico has created a *de facto* congregate setting for immigrants, since large groups of people are concentrated on the US southern border as a result of the MPP program in the worst of hygienic conditions without any basic public health infrastructure or access to medical facilities or the ability to engage in social distancing as they await asylum hearings, which are currently on hold as a consequence of the government's response to stop the spread of the coronavirus.¹³ This is a tinderbox that cannot be ignored in the national strategy to slow the spread of infection.

ICE recently announced that in response to the coronavirus pandemic, it will delay arresting immigrants who do not pose public safety threats, and will also stop detaining immigrants who fall outside of mandatory detention guidelines.¹⁴ But with reporting that immigrant detainees at ICE facilities are already being isolated for possible exposure to coronavirus, it is not enough to simply stop adding to the existing population of immigrant detainees. Social distancing through release is necessary to slow transmission of infection.¹⁵

Reassessing the security and public health risks, and acting immediately, will save lives of not only those detained, but also detention staff and their families, and the community-at-large.

¹² Report of the DHS Advisory Committee on Family Residential Centers, September 30, 2016, available at <https://www.ice.gov/sites/default/files/documents/Report/2016/ACFRC-sc16093.pdf>

¹³ See Rick Jervis, "Migrants waiting at US-Mexico border at risk of coronavirus, health experts warn," *USA Today*, March 17, 2020, available at <https://www.usatoday.com/story/news/nation/2020/03/17/us-border-could-hit-hard-coronavirus-migrants-wait-mexico/5062446002/>.

¹⁴ ICE website, Guidance on COVID-19, Immigration and Enforcement Check-Ins, Updated March 18, 2020, 7:45 pm, available at <https://www.ice.gov/covid19>.

¹⁵ Release of immigrants from detention to control the coronavirus outbreak has been recommended by John Sandweg, former acting head of ICE during the Obama administration, who further noted, "The overwhelming majority of people in ICE detention don't pose a threat to public safety and are not an unmanageable flight risk.'...? Unlike the Federal Bureau of Prisons, ICE has complete control over the release of individuals. ICE is not carrying out the sentence imposed by a federal judge.... It has 100% discretion.'" See Camilo Montoya-Galvez, "'Powder kegs': Calls grow for ICE to release immigrants to avoid coronavirus outbreak," *CBS News*, March 19, 2020, available at <https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak/>.

Our legal counsel, Dana Gold of the Government Accountability Project, is supporting and coordinating our efforts to share our concerns with Congress and other oversight entities about the substantial and specific threats to public health and safety the coronavirus poses by congregate settings for immigrants. As we similarly offered to DHS, we stand ready to aid you in any way to mitigate this crisis and prevent its escalation in light of our unique expertise in detention health and experience with ICE detention specifically. Please contact our attorney, Dana Gold, at danag@whistleblower.org, or her colleague, Irvin McCullough, at irvinm@whistleblower.org, with any questions.

Sincerely,

/s/

Scott A. Allen, MD, FACP
Professor Emeritus, University of California, School of Medicine
Medical Subject Matter Expert, CRCL, DHS

/s/

Josiah D. Rich, MD, MPH
Professor of Medicine and Epidemiology
The Warren Alpert Medical School of Brown University
Medical Subject Matter Expert, CRCL, DHS

Cc: Dana Gold, Esq. and Irvin McCullough, Government Accountability Project
Senate Committee on the Judiciary
House Committee on the Judiciary
White House Coronavirus Task Force

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.
2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.
3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.
4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
5. I am being paid \$1,000 for my time reviewing materials and preparing this report.
6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.
9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.
10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.
11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.
12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.¹ This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.
14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.
15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.
16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.
18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

¹ *Active case finding for communicable diseases in prisons*, 391 *The Lancet* 2186 (2018), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31251-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext).

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.² Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.³ Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease⁴

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

² *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012),

<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

³ David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), <https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/>.

⁴ This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, <https://www.cdc.gov/coronavirus/2019-ncov/index.html>; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), <https://www.nchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections>.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.⁵ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.⁶ Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.
22. The care of people who are infected with COVID-19 depends on how seriously they are ill.⁷ People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.
24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.⁸ To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

⁵ *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/summary.html>.

⁶ *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*. *The Lancet* (published online March 11, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext)

⁷ *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

⁸ *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), <https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5>.

place.⁹ Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice: New Jersey, Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.
26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.
27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.
28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.
29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.
30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

⁹ Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), <https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690>.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.
32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.
33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.
34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.
35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.
37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.
38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.
39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.
40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

March 15, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

EXHIBIT A

CURRICULUM VITAE

Date of Revision: November 20, 2019
 Name: Jaimie Meyer, MD, MS, FACP
 School: Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
 MD, University of Connecticut School of Medicine 2005
 MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008 Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
 2008 - 2011 Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
 2008 - 2012 Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
 2010 - 2012 Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
 2012 - 2014 Instructor, AIDS, Yale School of Medicine, New Haven, CT
 2014 - present Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
 2015 - 2018 Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
 AB of Internal Medicine, Infectious Disease, 10-2010
 AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018 NIH Center for Scientific Review, Selected as Early Career Reviewer
 2017 Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
 2016 American College of Physicians, Fellow
 2016 NIH Health Disparities, Loan Repayment Award Competitive Renewal
 2016 AAMC, Early Career Women Faculty Professional Development Seminar
 2014 NIH Health Disparities, Loan Repayment Program Award
 2014 NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
 2014 International Women's/Children's Health & Gender Working Group, Travel Award
 2014 Patterson Trust, Awards Program in Clinical Research
 2013 Connecticut Infectious Disease Society, Thornton Award for Clinical Research
 2011 Bristol Myers-Squibb, Virology Fellows Award

2006	NY Columbia Presbyterian, John N. Loeb Intern Award
2005	American Medical Women's Association, Medical Student Citation
2005	Connecticut State Medical Society, Medical Student Award
2000	Dartmouth College, Hannah Croasdale Senior Award
2000	Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University

2014	Women's Faculty Forum, Public Voices Thought Leadership Program Fellow
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Grants/Clinical Trials History:

Current Grants

Agency:	Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#:	2019-20 Pilot Project Awards
Title:	Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.:	Tiara Willie
Role:	Principal Investigator
Percent effort:	2%
Direct costs per year:	\$29,993.00
Total costs for project period:	\$29,993.00
Project period:	7/11/2019 - 7/10/2020

Agency:	SAMHSA
I.D.#:	H79 TI080561
Title:	CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role:	Principal Investigator
Percent effort:	20%
Direct costs per year:	\$389,054.00
Total costs for project period:	\$1,933,368.00
Project period:	11/30/2018 - 11/29/2023

Agency:	Gilead Sciences, Inc.
I.D.#:	Investigator Sponsored Award, CO-US-276-D136
Title:	Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role:	Principal Investigator
Percent effort:	8%
Direct costs per year:	\$81,151.00
Total costs for project	

period: \$306,199.00
Project period: 6/19/2018 - 1/31/2020

Agency: NIDA
I.D.#: R21 DA042702
Title: Prisons, Drug Injection and the HIV Risk Environment
Role: Principal Investigator
Percent effort: 22%
Direct costs per year: \$129,673.00
Total costs for project period: \$358,276.00
Project period: 8/1/2017 - 7/31/2020

Agency: Doris Duke Charitable Foundation
I.D.#: Clinical Scientist Development Award
Title: Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Role: Principal Investigator
Percent effort: 27%
Direct costs per year: \$149,959.00
Total costs for project period: \$493,965.00
Project period: 7/1/2017 - 6/30/2020

Past Grants

Agency: NIDA
I.D.#: K23 DA033858
Title: Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
Role: Principal Investigator
Percent effort: 75%
Direct costs per year: \$149,509.00
Total costs for project period: \$821,147.00
Project period: 7/1/2012 - 11/30/2017

Agency: Robert Leet & Clara Guthrie Patterson Trust
I.D.#: R12225, Award in Clinical Research
Title: Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
Role: Principal Investigator
Percent effort: 10%
Direct costs per year: \$75,000.00

Total costs for project

period: \$75,000.00
 Project period: 1/31/2014 - 10/31/2015

Agency: Bristol-Myers Squibb
 I.D.#: HIV Virology Fellowship Award
 Title: Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
 Role: Principal Investigator
 Percent effort: 10%
 Direct costs per year: \$34,390.00
 Total costs for project
 period: \$34,390.00
 Project period: 12/1/2011 - 11/30/2012

Pending Grants

Agency: NIMH
 I.D.#: R01 MH121991
 Title: Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
 P.I.: Sullivan, Tami
 Role: Principal Investigator
 Percent effort: 30%
 Direct costs per year: \$499,755.00
 Total costs for project
 period: \$4,148,823.00
 Project period: 1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:**International/National**

- 2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"
- 2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"
- 2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"
- 2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"
- 2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"
- 2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

- 2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"
- 2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"
- 2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"
- 2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"
- 2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:**International/National**

- 2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"
- 2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"
- 2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"
- 2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"
- 2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"
- 2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""
- 2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"
- 2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"
- 2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"
- 2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

- 2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"
- 2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"
- 2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"
- 2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"
- 2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"
- 2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"
- 2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"
- 2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"
- 2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"
- 2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

- 2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"
- 2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"
- 2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"
- 2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"
- 2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"
- 2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

- 2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"
- 2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"
- 2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

- 2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

- 2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers
- 2019 - present Reviewer, Yale DCFAR Pilot Projects
- 2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)
- 2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

- 2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

- 2019 - present Associate Editor, Journal of the International Association of Providers of AIDS Care (JIAPAC), Section Editor: Sex and Gender Issues

Reviewer

- 2019 - present Reviewer, JAIDS
- 2012 - present Reviewer, Addiction Sci and Clin Pract
- 2012 - present Reviewer, Addictive Behav Reports
- 2012 - present Reviewer, AIDS Care
- 2012 - present Reviewer, Social Science and Medicine
- 2012 - present Reviewer, SpringerPlus
- 2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy
- 2012 - present Reviewer, Women's Health Issues
- 2012 - present Reviewer, Yale Journal of Biology and Medicine
- 2012 - present Reviewer, AIMS Public Health
- 2012 - present Reviewer, American Journal on Addictions
- 2012 - present Reviewer, American Journal of Epidemiology
- 2012 - present Reviewer, American Journal of Public Health
- 2012 - present Reviewer, Annals Internal Medicine
- 2012 - present Reviewer, BMC Emergency Medicine
- 2012 - present Reviewer, BMC Infectious Diseases
- 2012 - present Reviewer, BMC Public Health
- 2012 - present Reviewer, BMC Women's Health

2012 - present Reviewer, Clinical Infectious Diseases
 2012 - present Reviewer, Critical Public Health
 2012 - present Reviewer, Drug and Alcohol Dependence
 2012 - present Reviewer, Drug and Alcohol Review
 2012 - present Reviewer, Epidemiologic Reviews
 2012 - present Reviewer, Eurosurveillance
 2012 - present Reviewer, Health and Justice (Springer Open)
 2012 - present Reviewer, International Journal of Drug Policy
 2012 - present Reviewer, International Journal of Prisoner Health
 2012 - present Reviewer, International Journal of STDs and AIDS
 2012 - present Reviewer, International Journal of Women's Health
 2012 - present Reviewer, JAMA Internal Medicine
 2012 - present Reviewer, Journal of Family Violence
 2012 - present Reviewer, Journal of General Internal Medicine
 2012 - present Reviewer, Journal of Immigrant and Minority Health
 2012 - present Reviewer, Journal of International AIDS Society
 2012 - present Reviewer, Journal of Psychoactive Drugs
 2012 - present Reviewer, Journal of Urban Health
 2012 - present Reviewer, Journal of Women's Health
 2012 - present Reviewer, Open Forum Infectious Diseases
 2012 - present Reviewer, PLoS ONE
 2012 - present Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

2016 - present Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians

2016 - present Fellow, American College of Physicians
 2013 - 2016 Member, American College of Physicians

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service*University Committees*

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine

2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School

2013 - present Mentor, Women in Medicine at Yale Mentoring Program

2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS

2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:**Peer-Reviewed Original Research**

1. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Emergency department use by released prisoners with HIV: an observational longitudinal study. *PloS One* 2012, 7:e42416.
2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. *Journal Of Immigrant And Minority Health / Center For Minority Public Health* 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. *AIDS And Behavior* 2013, 17 Suppl 2:S118-27.

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DECLARATION OF O.M.G.

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. I am the plaintiff identified as O.M.G. in the above-styled matter. I am the mother of the plaintiff identified as H.F.G.M., who is four years old. My daughter and I are currently detained at the South Texas Family Residential Center, 300 El Rancho Way, Dilley, Texas, 78017. We are from Honduras and seek asylum in the United States.
2. On February 5, 2020 I was detained by ICE in Tennessee with my daughter. I was placed in detention at the South Texas Family Residential Center on February 6, 2020.
3. I am a plaintiff in this case because I fear that I will contract the Corona virus while detained. I fear me, my daughter, and my unborn fetus will die if we become sick in detention.
4. I am almost seven months pregnant and due to deliver a little girl on June 27, 2020. I have a history of complications in pregnancy that have gone untreated while detained. I have previously had a miscarriage. Prior to my detention I was under the care of an OBGYN who placed me on four different medications, in addition to my prenatal vitamins. I have not had regular access to an OBGYN in Dilley and have been denied the medications prescribed by my prior physician while detained.
5. I have developed an infection in Dilley that causes me severe pain in my uterine and pain when I urinate. When I initially sought medical care for this pain at this jail, the medical staff advised me to drink water. I was later prescribed a cream, and subsequently antibiotics. The cream and antibiotics did not resolve my pain or end the infection. The infection has progressed and I now feel excruciating pain, not only when urinating, but when walking and standing, and in my waist.
6. On March 6, 2020 I was taken to San Antonio, Texas to meet with a gynecologist. The doctor informed me that my infection continued, and could result in another miscarriage and birth defects for my child. I was told that I am also at high risk for preeclampsia, which can lead to a stroke, seizure, fluid in my chest, heart failure, blindness, or dangerous bleeding. Preeclampsia could also cause premature birth and complications for my baby, including learning disabilities, epilepsy, cerebral palsy, and hearing and vision problems.
7. There is no gynecologist at the jail in Dilley. If I have an urgent medical need regarding my pregnancy, I would need to be transported to San Antonio, which is about an hour and a half away. I am very worried about what would happen if I go into labor while detained.
8. In addition to the challenges I face in my pregnancy, I have other medical conditions. I have a history of passing out. I have blacked out two times while detained. One time I

passed out in the library, and one time in my room. People who have observed me when I have fainted say that I convulse. I also have severe allergies and an elevated heart rate. Currently, I feel dizzy and tired all of the time.

9. My daughter also has medical issues which have developed while detained and gone untreated. My daughter has a cough that has not subsided for four days. She coughs to the point of vomiting. Sometimes she vomits three times in one night. The doctors in this detention center have provided her with Vick's and given her water. This has not helped and she has stopped eating.
10. I do not have access to the medical attention I need in this jail. Despite my medical condition, the facility continues to assign me the task of sweeping my dormitory, which is difficult for me because it is hard for me to move and walk. In fact, when I have told the guards that I am in pain and cannot sweep, I have been threatened with being written up.
11. I fear the Corona virus will spread quickly in this jail if one person is infected. The guards have not given us any information about the disease, or how we can protect ourselves from getting it. The jail has not increased our access to hand soap or hand sanitizer, and there are no new efforts to ensure everyone detained here washes their hands. I have not seen any heightened cleaning procedures. The contracted cleaners clean my dorm room once a week. Detained families are required to do the additional cleaning. However, we are not given supplies other than a broom.
12. I am most afraid because I cannot keep a sufficient distance from other people to keep myself safe from contracting the virus if they have it. I must be close to others all of the time. I share a room, bathroom, and the dining hall. All locations in this jail are communal.
13. Today one of my friends told me that she spoke with a guard this morning that tested positive for the Corona virus. The guard told my friend she is better now, and did not come to work for a few days while she recovered. This guard is an older white woman with glasses and blonde hair.
14. For all of these reasons, I fear for my life, and the life of my daughter and unborn child, if we remain detained. I believe our safety requires our release.
15. This declaration was read to me in Spanish by Shalyn Fluharty, an attorney with the Dilley Pro Bono Project. It is true and correct to the best of my knowledge.

Declaration of C.L.

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. I am the plaintiff identified as C.L. in the above-styled matter. I am the mother of the plaintiff identified as J.A. My son and I are currently detained at the South Texas Family Residential Center, 300 El Rancho Way, Dilley, Texas, 78017. I am a Haitian national; my son is a Brazilian national. We are currently seeking asylum in the United States.
2. I fled Haiti because I was threatened with death by members of my father's family who killed my relatives and burned down our house. I fled to Brazil, where I gave birth to my son. I later had to flee Brazil because I was beaten and abused by my partner there.
3. I am scared of getting sick with the coronavirus while my son and I are detained here. We have been detained here for fifty-four days, and we are both sick. In addition, my son has asthma. I have heard that people with asthma are more at risk for the coronavirus, and I am terrified of what would happen if the coronavirus got to the detention center. There is nothing being done here to protect us from the coronavirus.

My child suffers from asthma, and the doctors here have not provided him with medication.

4. My son has suffered from asthma his entire life. He was diagnosed with asthma when he was eight or nine months old. Since then, he has taken medication and had an inhaler in order to control his asthma.
5. While I was in Mexico on my way to the United States, I lost my son's inhaler. Shortly after I arrived at Dilley, I went to the medical clinic here and told them my son had asthma and asked them for an inhaler. They did not do any tests on my son to check on his breathing, and they did not give me an inhaler.
6. My son had an asthma attack in February 2020, while we were detained. He was struggling to breathe, so I took him to the clinic. They gave him medicine for his cough, and some allergy medication, but they did not give him an inhaler.
7. My son still has a cough and has had a cough the entire time we have been detained at Dilley. He has also developed a stuffy nose. At the moment, my son is without any form of medication for his asthma. I am terrified that he could have an asthma attack and die here because we have not been given the medication he needs.

I am suffering from heart palpitations and chest pain while in detention.

8. I have been experiencing chest pains while I have been detained at Dilley. On several occasions, I have had episodes where I am walking and experience strong heart palpitations. When I have these episodes, I feel like it is hard to breathe, I feel pain in my chest, and I have a hard time walking and standing upright.
9. I have also started having strong headaches. There are times that my head hurts so bad that I can't read.

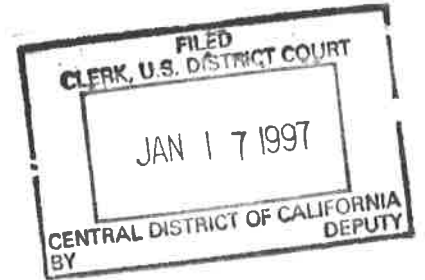
Nothing is being done at the detention center to protect us from the coronavirus.

10. I am very concerned for my son's health. Because he already has breathing problems and has been coughing for almost two months now, I am very afraid that if the coronavirus gets into the detention center, he will be in great danger.
11. I am also very concerned because the people here are doing nothing to protect us from the coronavirus. My son and I are in a room with about nine other people. We sleep very close together, and there is very little space to maintain distance from other people when we are in the room. When I am laying down in my bed, I can touch the bed next to me. My son has a cough and other people in our room also have a cough. They have never quarantined the people who have a cough.
12. I don't know how I can avoid getting the coronavirus. I recently noticed a sign in our bathroom that says something about washing your hands, but it is only in Spanish and English. My primary language is Haitian Creole, and I haven't received any information in Haitian Creole. No one here has talked to me about the coronavirus.
13. We have a very hard time washing our hands as well. The soap in our room runs out very quickly, and then it takes a long time for it to be replaced. There have been occasions where it is a whole day before there is more soap in the room. There is no hand sanitizer in our room. We are also not provided with disinfectant wipes to clean our room.
14. Almost everything we do here requires us to be very close together. The school is still open here, and there are about twenty children in the classroom at a time. I am scared to send my son to school for that reason. We are also all required to eat in one cafeteria, which is very crowded. Everyone is serving themselves from the same spoon and using the same pitcher. I'm afraid that by the time they notice that someone here has the virus, it will be too late because everyone will be infected.
15. I haven't seen anyone with a facemask or with gloves. Even people that are coughing are not given facemasks. When I was at the medical clinic here last week, I saw some doctors meet with patients without facemasks.

8/12/96

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

JENNY LISETTE FLORES, et al.,)	Case No. CV 85-4544-RJK(Px)
)	
Plaintiffs,)	Stipulated Settlement
)	Agreement
-vs-)	
)	
JANET RENO, Attorney General)	
of the United States, et al.,)	
)	
Defendants.)	

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STIPULATED SETTLEMENT AGREEMENT

WHEREAS, Plaintiffs have filed this action against Defendants, challenging, *inter alia*, the constitutionality of Defendants' policies, practices and regulations regarding the detention and release of unaccompanied minors taken into the custody of the Immigration and Naturalization Service (INS) in the Western Region; and

WHEREAS, the district court has certified this case as a class action on behalf of all minors apprehended by the INS in the Western Region of the United States; and

WHEREAS, this litigation has been pending for nine (9) years, all parties have conducted extensive discovery, and the United States Supreme Court has upheld the constitutionality of the challenged INS regulations on their face and has remanded for further proceedings consistent with its opinion; and

WHEREAS, on November 30, 1987, the parties reached a settlement agreement requiring that minors in INS custody in the Western Region be housed in facilities meeting certain standards, including state standards for the housing and care of dependent children, and Plaintiffs' motion to enforce compliance with that settlement is currently pending before the court; and

WHEREAS, a trial in this case would be complex, lengthy and costly to all parties concerned, and the decision of the district court would be subject to appeal by the losing parties with the final outcome uncertain; and

WHEREAS, the parties believe that settlement of this action is in their best interests and best serves the interests of justice by avoiding a complex, lengthy and costly trial, and subsequent appeals which could last several more years;

NOW, THEREFORE, Plaintiffs and Defendants enter into this Stipulated Settlement Agreement

(the Agreement), stipulate that it constitutes a full and complete resolution of the issues raised in this action, and agree to the following:

I DEFINITIONS

As used throughout this Agreement the following definitions shall apply:

1. The term "party" or "parties" shall apply to Defendants and Plaintiffs. As the term applies to Defendants, it shall include their agents, employees, contractors and/or successors in office. As the term applies to Plaintiffs, it shall include all class members.

2. The term "Plaintiff" or "Plaintiffs" shall apply to the named plaintiffs and all class members.

3. The term "class member" or "class members" shall apply to the persons defined in Paragraph 10 below.

4. The term "minor" shall apply to any person under the age of eighteen (18) years who is detained in the legal custody of the INS. This Agreement shall cease to apply to any person who has reached the age of eighteen years. The term "minor" shall not include an emancipated minor or an individual who has been incarcerated due to a conviction for a criminal offense as an adult. The INS shall treat all persons who are under the age of eighteen but not included within the definition of "minor" as adults for all purposes, including release on bond or recognizance.

5. The term "emancipated minor" shall refer to any minor who has been determined to be emancipated in an appropriate state judicial proceeding.

6. The term "licensed program" shall refer to any program, agency or organization that is licensed by an appropriate State agency to provide residential, group, or foster care services for dependent children, including a program operating group homes, foster homes, or facilities for special needs minors. A licensed program must also meet those standards for licensed programs set forth in

Exhibit 1 attached hereto. All homes and facilities operated by licensed programs, including facilities for special needs minors, shall be non-secure as required under state law; provided, however, that a facility for special needs minors may maintain that level of security permitted under state law which is necessary for the protection of a minor or others in appropriate circumstances, *e.g.*, cases in which a minor has drug or alcohol problems or is mentally ill. The INS shall make reasonable efforts to provide licensed placements in those geographical areas where the majority of minors are apprehended, such as southern California, southeast Texas, southern Florida and the northeast corridor.

7. The term "special needs minor" shall refer to a minor whose mental and/or physical condition requires special services and treatment by staff. A minor may have special needs due to drug or alcohol abuse, serious emotional disturbance, mental illness or retardation, or a physical condition or chronic illness that requires special services or treatment. A minor who has suffered serious neglect or abuse may be considered a minor with special needs if the minor requires special services or treatment as a result of the neglect or abuse. The INS shall assess minors to determine if they have special needs and, if so, shall place such minors, whenever possible, in licensed programs in which the INS places children without special needs, but which provide services and treatment for such special needs.

8. The term "medium security facility" shall refer to a facility that is operated by a program, agency or organization licensed by an appropriate State agency and that meets those standards set forth in Exhibit 1 attached hereto. A medium security facility is designed for minors who require close supervision but do not need placement in juvenile correctional facilities. It provides 24-hour awake supervision, custody, care, and treatment. It maintains stricter security measures, such as intensive staff supervision, than a facility operated by a licensed program in order to control problem behavior and to prevent escape. Such a facility may have a secure perimeter but shall not be equipped internally with

major restraining construction or procedures typically associated with correctional facilities.

II SCOPE OF SETTLEMENT, EFFECTIVE DATE, AND PUBLICATION

9. This Agreement sets out nationwide policy for the detention, release, and treatment of minors in the custody of the INS and shall supersede all previous INS policies that are inconsistent with the terms of this Agreement. This Agreement shall become effective upon final court approval, except that those terms of this Agreement regarding placement pursuant to Paragraph 19 shall not become effective until all contracts under the Program Announcement referenced in Paragraph 20 below are negotiated and implemented. The INS shall make its best efforts to execute these contracts within 120 days after the court's final approval of this Agreement. However, the INS will make reasonable efforts to comply with Paragraph 19 prior to full implementation of all such contracts. Once all contracts under the Program Announcement referenced in Paragraph 20 have been implemented, this Agreement shall supersede the agreement entitled Memorandum of Understanding Re Compromise of Class Action: Conditions of Detention (hereinafter "MOU"), entered into by and between the Plaintiffs and Defendants and filed with the United States District Court for the Central District of California on November 30, 1987, and the MOU shall thereafter be null and void. However, Plaintiffs shall not institute any legal action for enforcement of the MOU for a six (6) month period commencing with the final district court approval of this Agreement, except that Plaintiffs may institute enforcement proceedings if the Defendants have engaged in serious violations of the MOU that have caused irreparable harm to a class member for which injunctive relief would be appropriate. Within 120 days of the final district court approval of this Agreement, the INS shall initiate action to publish the relevant and substantive terms of this Agreement as a Service regulation. The final regulations shall not be inconsistent with the terms of this Agreement. Within 30 days of final court approval of this

Agreement, the INS shall distribute to all INS field offices and sub-offices instructions regarding the processing, treatment, and placement of juveniles. Those instructions shall include, but may not be limited to, the provisions summarizing the terms of this Agreement, attached hereto as Exhibit 2.

III CLASS DEFINITION

10. The certified class in this action shall be defined as follows: "All minors who are detained in the legal custody of the INS."

IV STATEMENTS OF GENERAL APPLICABILITY

11. The INS treats, and shall continue to treat, all minors in its custody with dignity, respect and special concern for their particular vulnerability as minors. The INS shall place each detained minor in the least restrictive setting appropriate to the minor's age and special needs, provided that such setting is consistent with its interests to ensure the minor's timely appearance before the INS and the immigration courts and to protect the minor's well-being and that of others. Nothing herein shall require the INS to release a minor to any person or agency whom the INS has reason to believe may harm or neglect the minor or fail to present him or her before the INS or the immigration courts when requested to do so.

V PROCEDURES AND TEMPORARY PLACEMENT FOLLOWING ARREST

12.A. Whenever the INS takes a minor into custody, it shall expeditiously process the minor and shall provide the minor with a notice of rights, including the right to a bond redetermination hearing if applicable. Following arrest, the INS shall hold minors in facilities that are safe and sanitary and that are consistent with the INS's concern for the particular vulnerability of minors. Facilities will provide access to toilets and sinks, drinking water and food as appropriate, medical assistance if the minor is in need of emergency services, adequate temperature control and ventilation, adequate supervision to

protect minors from others, and contact with family members who were arrested with the minor. The INS will segregate unaccompanied minors from unrelated adults. Where such segregation is not immediately possible, an unaccompanied minor will not be detained with an unrelated adult for more than 24 hours. If there is no one to whom the INS may release the minor pursuant to Paragraph 14, and no appropriate licensed program is immediately available for placement pursuant to Paragraph 19, the minor may be placed in an INS detention facility, or other INS-contracted facility, having separate accommodations for minors, or a State or county juvenile detention facility. However, minors shall be separated from delinquent offenders. Every effort must be taken to ensure that the safety and well-being of the minors detained in these facilities are satisfactorily provided for by the staff. The INS will transfer a minor from a placement under this paragraph to a placement under Paragraph 19, (i) within three (3) days, if the minor was apprehended in an INS district in which a licensed program is located and has space available; or (ii) within five (5) days in all other cases; except:

1. as otherwise provided under Paragraph 13 or Paragraph 21;
2. as otherwise required by any court decree or court-approved settlement;
3. in the event of an emergency or influx of minors into the United States, in which case the INS shall place all minors pursuant to Paragraph 19 as expeditiously as possible; or
4. where individuals must be transported from remote areas for processing or speak unusual languages such that the INS must locate interpreters in order to complete processing, in which case the INS shall place all such minors pursuant to Paragraph 19 within five (5) business days.

B. For purposes of this paragraph, the term "emergency" shall be defined as any act or event that prevents the placement of minors pursuant to Paragraph 19 within the time frame provided. Such

emergencies include natural disasters (e.g., earthquakes, hurricanes, etc.), facility fires, civil disturbances, and medical emergencies (e.g., a chicken pox epidemic among a group of minors). The term "influx of minors into the United States" shall be defined as those circumstances where the INS has, at any given time, more than 130 minors eligible for placement in a licensed program under Paragraph 19, including those who have been so placed or are awaiting such placement.

C. In preparation for an "emergency" or "influx," as described in Subparagraph B, the INS shall have a written plan that describes the reasonable efforts that it will take to place all minors as expeditiously as possible. This plan shall include the identification of 80 beds that are potentially available for INS placements and that are licensed by an appropriate State agency to provide residential, group, or foster care services for dependent children. The plan, without identification of the additional beds available, is attached as Exhibit 3. The INS shall not be obligated to fund these additional beds on an ongoing basis. The INS shall update this listing of additional beds on a quarterly basis and provide Plaintiffs' counsel with a copy of this listing.

13. If a reasonable person would conclude that an alien detained by the INS is an adult despite his claims to be a minor, the INS shall treat the person as an adult for all purposes, including confinement and release on bond or recognizance. The INS may require the alien to submit to a medical or dental examination conducted by a medical professional or to submit to other appropriate procedures to verify his or her age. If the INS subsequently determines that such an individual is a minor, he or she will be treated as a minor in accordance with this Agreement for all purposes.

VI GENERAL POLICY FAVORING RELEASE

14. Where the INS determines that the detention of the minor is not required either to secure his or her timely appearance before the INS or the immigration court, or to ensure the minor's safety or that

of others, the INS shall release a minor from its custody without unnecessary delay, in the following order of preference, to:

- A. a parent;
- B. a legal guardian;
- C. an adult relative (brother, sister, aunt, uncle, or grandparent);
- D. an adult individual or entity designated by the parent or legal guardian as capable and willing to care for the minor's well-being in (i) a declaration signed under penalty of perjury before an immigration or consular officer or (ii) such other document(s) that establish(es) to the satisfaction of the INS, in its discretion, the affiant's paternity or guardianship;
- E. a licensed program willing to accept legal custody; or
- F. an adult individual or entity seeking custody, in the discretion of the INS, when it appears that there is no other likely alternative to long term detention and family reunification does not appear to be a reasonable possibility.

15. Before a minor is released from INS custody pursuant to Paragraph 14 above, the custodian must execute an Affidavit of Support (Form I-134) and an agreement to:

- A. provide for the minor's physical, mental, and financial well-being;
- B. ensure the minor's presence at all future proceedings before the INS and the immigration court;
- C. notify the INS of any change of address within five (5) days following a move;
- D. in the case of custodians other than parents or legal guardians, not transfer custody of the minor to another party without the prior written permission of the District Director;

- E. notify the INS at least five days prior to the custodian's departing the United States of such departure, whether the departure is voluntary or pursuant to a grant of voluntary departure or order of deportation; and
- F. if dependency proceedings involving the minor are initiated, notify the INS of the initiation of such proceedings and the dependency court of any immigration proceedings pending against the minor.

In the event of an emergency, a custodian may transfer temporary physical custody of a minor prior to securing permission from the INS but shall notify the INS of the transfer as soon as is practicable thereafter, but in all cases within 72 hours. For purposes of this paragraph, examples of an "emergency" shall include the serious illness of the custodian, destruction of the home, etc. In all cases where the custodian, in writing, seeks written permission for a transfer, the District Director shall promptly respond to the request.

16. The INS may terminate the custody arrangements and assume legal custody of any minor whose custodian fails to comply with the agreement required under Paragraph 15. The INS, however, shall not terminate the custody arrangements for minor violations of that part of the custodial agreement outlined at Subparagraph 15.C above.

17. A positive suitability assessment may be required prior to release to any individual or program pursuant to Paragraph 14. A suitability assessment may include such components as an investigation of the living conditions in which the minor would be placed and the standard of care he would receive, verification of identity and employment of the individuals offering support, interviews of members of the household, and a home visit. Any such assessment should also take into consideration the wishes and concerns of the minor.

18. Upon taking a minor into custody, the INS, or the licensed program in which the minor is placed, shall make and record the prompt and continuous efforts on its part toward family reunification and the release of the minor pursuant to Paragraph 14 above. Such efforts at family reunification shall continue so long as the minor is in INS custody.

VII INS CUSTODY

19. In any case in which the INS does not release a minor pursuant to Paragraph 14, the minor shall remain in INS legal custody. Except as provided in Paragraphs 12 or 21, such minor shall be placed temporarily in a licensed program until such time as release can be effected in accordance with Paragraph 14 above or until the minor's immigration proceedings are concluded, whichever occurs earlier. All minors placed in such a licensed program remain in the legal custody of the INS and may only be transferred or released under the authority of the INS; provided, however, that in the event of an emergency a licensed program may transfer temporary physical custody of a minor prior to securing permission from the INS but shall notify the INS of the transfer as soon as is practicable thereafter, but in all cases within 8 hours.

20. Within 60 days of final court approval of this Agreement, the INS shall authorize the United States Department of Justice Community Relations Service to publish in the Commerce Business Daily and/or the Federal Register a Program Announcement to solicit proposals for the care of 100 minors in licensed programs.

21. A minor may be held in or transferred to a suitable State or county juvenile detention facility or a secure INS detention facility, or INS-contracted facility, having separate accommodations for minors whenever the District Director or Chief Patrol Agent determines that the minor:

A. has been charged with, is chargeable, or has been convicted of a crime, or is the subject

of delinquency proceedings, has been adjudicated delinquent, or is chargeable with a delinquent act; provided, however, that this provision shall not apply to any minor whose offense(s) fall(s) within either of the following categories:

- i. Isolated offenses that (1) were not within a pattern or practice of criminal activity and (2) did not involve violence against a person or the use or carrying of a weapon (Examples: breaking and entering, vandalism, DUI, etc. This list is not exhaustive.);
- ii. Petty offenses, which are not considered grounds for stricter means of detention in any case (Examples: shoplifting, joy riding, disturbing the peace, etc. This list is not exhaustive.);

As used in this paragraph, "chargeable" means that the INS has probable cause to believe that the individual has committed a specified offense;

- B. has committed, or has made credible threats to commit, a violent or malicious act (whether directed at himself or others) while in INS legal custody or while in the presence of an INS officer;
- C. has engaged, while in a licensed program, in conduct that has proven to be unacceptably disruptive of the normal functioning of the licensed program in which he or she has been placed and removal is necessary to ensure the welfare of the minor or others, as determined by the staff of the licensed program (Examples: drug or alcohol abuse, stealing, fighting, intimidation of others, etc. This list is not exhaustive.);
- D. is an escape-risk; or
- E. must be held in a secure facility for his or her own safety, such as when the INS has

reason to believe that a smuggler would abduct or coerce a particular minor to secure payment of smuggling fees.

22. The term "escape-risk" means that there is a serious risk that the minor will attempt to escape from custody. Factors to consider when determining whether a minor is an escape-risk or not include, but are not limited to, whether:

- A. the minor is currently under a final order of deportation or exclusion;
- B. the minor's immigration history includes: a prior breach of a bond; a failure to appear before the INS or the immigration court; evidence that the minor is indebted to organized smugglers for his transport; or a voluntary departure or a previous removal from the United States pursuant to a final order of deportation or exclusion;
- C. the minor has previously absconded or attempted to abscond from INS custody.

23. The INS will not place a minor in a secure facility pursuant to Paragraph 21 if there are less restrictive alternatives that are available and appropriate in the circumstances, such as transfer to (a) a medium security facility which would provide intensive staff supervision and counseling services or (b) another licensed program. All determinations to place a minor in a secure facility will be reviewed and approved by the regional juvenile coordinator.

24.A. A minor in deportation proceedings shall be afforded a bond redetermination hearing before an immigration judge in every case, unless the minor indicates on the Notice of Custody Determination form that he or she refuses such a hearing.

B. Any minor who disagrees with the INS's determination to place that minor in a particular type of facility, or who asserts that the licensed program in which he or she has been placed does not comply with the standards set forth in Exhibit 1 attached hereto, may seek judicial review in any

United States District Court with jurisdiction and venue over the matter to challenge that placement determination or to allege noncompliance with the standards set forth in Exhibit 1. In such an action, the United States District Court shall be limited to entering an order solely affecting the individual claims of the minor bringing the action.

C. In order to permit judicial review of Defendants' placement decisions as provided in this Agreement, Defendants shall provide minors not placed in licensed programs with a notice of the reasons for housing the minor in a detention or medium security facility. With respect to placement decisions reviewed under this paragraph, the standard of review for the INS's exercise of its discretion shall be the abuse of discretion standard of review. With respect to all other matters for which this paragraph provides judicial review, the standard of review shall be *de novo* review.

D. The INS shall promptly provide each minor not released with (a) INS Form I-770, (b) an explanation of the right of judicial review as set out in Exhibit 6, and (c) the list of free legal services available in the district pursuant to INS regulations (unless previously given to the minor).

E. Exhausting the procedures established in Paragraph 37 of this Agreement shall not be a precondition to the bringing of an action under this paragraph in any United District Court. Prior to initiating any such action, however, the minor and/or the minors' attorney shall confer telephonically or in person with the United States Attorney's office in the judicial district where the action is to be filed, in an effort to informally resolve the minor's complaints without the need of federal court intervention.

VIII TRANSPORTATION OF MINORS

25. Unaccompanied minors arrested or taken into custody by the INS should not be transported by the INS in vehicles with detained adults except:

A. when being transported from the place of arrest or apprehension to an INS office, or

B. where separate transportation would be otherwise impractical.

When transported together pursuant to Clause B, minors shall be separated from adults. The INS shall take necessary precautions for the protection of the well-being of such minors when transported with adults.

26. The INS shall assist without undue delay in making transportation arrangements to the INS office nearest the location of the person or facility to whom a minor is to be released pursuant to Paragraph 14. The INS may, in its discretion, provide transportation to minors.

IX TRANSFER OF MINORS

27. Whenever a minor is transferred from one placement to another, the minor shall be transferred with all of his or her possessions and legal papers; provided, however, that if the minor's possessions exceed the amount permitted normally by the carrier in use, the possessions will be shipped to the minor in a timely manner. No minor who is represented by counsel shall be transferred without advance notice to such counsel, except in unusual and compelling circumstances such as where the safety of the minor or others is threatened or the minor has been determined to be an escape-risk, or where counsel has waived such notice, in which cases notice shall be provided to counsel within 24 hours following transfer.

X MONITORING AND REPORTS

28A. An INS Juvenile Coordinator in the Office of the Assistant Commissioner for Detention and Deportation shall monitor compliance with the terms of this Agreement and shall maintain an up-to-date record of all minors who are placed in proceedings and remain in INS custody for longer than 72 hours. Statistical information on such minors shall be collected weekly from all INS district offices and Border Patrol stations. Statistical information will include at least the following: (1)

biographical information such as each minor's name, date of birth, and country of birth, (2) date placed in INS custody, (3) each date placed, removed or released, (4) to whom and where placed, transferred, removed or released, (5) immigration status, and (6) hearing dates. The INS, through the Juvenile Coordinator, shall also collect information regarding the reasons for every placement of a minor in a detention facility or medium security facility.

B. Should Plaintiffs' counsel have reasonable cause to believe that a minor in INS legal custody should have been released pursuant to Paragraph 14, Plaintiffs' counsel may contact the Juvenile Coordinator to request that the Coordinator investigate the case and inform Plaintiffs' counsel of the reasons why the minor has not been released.

29. On a semi-annual basis, until two years after the court determines, pursuant to Paragraph 31, that the INS has achieved substantial compliance with the terms of this Agreement, the INS shall provide to Plaintiffs' counsel the information collected pursuant to Paragraph 28, as permitted by law, and each INS policy or instruction issued to INS employees regarding the implementation of this Agreement. In addition, Plaintiffs' counsel shall have the opportunity to submit questions, on a semi-annual basis, to the Juvenile Coordinator in the Office of the Assistant Commissioner for Detention and Deportation with regard to the implementation of this Agreement and the information provided to Plaintiffs' counsel during the preceding six-month period pursuant to Paragraph 28. Plaintiffs' counsel shall present such questions either orally or in writing, at the option of the Juvenile Coordinator. The Juvenile Coordinator shall furnish responses, either orally or in writing at the option of Plaintiffs' counsel, within 30 days of receipt.

30. On an annual basis, commencing one year after final court approval of this Agreement, the INS Juvenile Coordinator shall review, assess, and report to the court regarding compliance with the

terms of this Agreement. The Coordinator shall file these reports with the court and provide copies to the parties, including the final report referenced in Paragraph 35, so that they can submit comments on the report to the court. In each report, the Coordinator shall state to the court whether or not the INS is in substantial compliance with the terms of this Agreement, and, if the INS is not in substantial compliance, explain the reasons for the lack of compliance. The Coordinator shall continue to report on an annual basis until three years after the court determines that the INS has achieved substantial compliance with the terms of this Agreement.

31. One year after the court's approval of this Agreement, the Defendants may ask the court to determine whether the INS has achieved substantial compliance with the terms of this Agreement.

XI ATTORNEY-CLIENT VISITS

32.A. Plaintiffs' counsel are entitled to attorney-client visits with class members even though they may not have the names of class members who are housed at a particular location. All visits shall occur in accordance with generally applicable policies and procedures relating to attorney-client visits at the facility in question. Upon Plaintiffs' counsel's arrival at a facility for attorney-client visits, the facility staff shall provide Plaintiffs' counsel with a list of names and alien registration numbers for the minors housed at that facility. In all instances, in order to memorialize any visit to a minor by Plaintiffs' counsel, Plaintiffs' counsel must file a notice of appearance with the INS prior to any attorney-client meeting. Plaintiffs' counsel may limit any such notice of appearance to representation of the minor in connection with this Agreement. Plaintiffs' counsel must submit a copy of the notice of appearance by hand or by mail to the local INS juvenile coordinator and a copy by hand to the staff of the facility.

B. Every six months, Plaintiffs' counsel shall provide the INS with a list of those attorneys who

may make such attorney-client visits, as Plaintiffs' counsel, to minors during the following six month period. Attorney-client visits may also be conducted by any staff attorney employed by the Center for Human Rights & Constitutional Law in Los Angeles, California or the National Center for Youth Law in San Francisco, California, provided that such attorney presents credentials establishing his or her employment prior to any visit.

C. Agreements for the placement of minors in non-INS facilities shall permit attorney-client visits, including by class counsel in this case.

D. Nothing in Paragraph 32 shall affect a minor's right to refuse to meet with Plaintiffs' counsel. Further, the minor's parent or legal guardian may deny Plaintiffs' counsel permission to meet with the minor.

XII FACILITY VISITS

33. In addition to the attorney-client visits permitted pursuant to Paragraph 32, Plaintiffs' counsel may request access to any licensed program's facility in which a minor has been placed pursuant to Paragraph 19 or to any medium security facility or detention facility in which a minor has been placed pursuant to Paragraphs 21 or 23. Plaintiffs' counsel shall submit a request to visit a facility under this paragraph to the INS district juvenile coordinator who will provide reasonable assistance to Plaintiffs' counsel by conveying the request to the facility's staff and coordinating the visit. The rules and procedures to be followed in connection with any visit approved by a facility under this paragraph are set forth in Exhibit 4 attached, except as may be otherwise agreed by Plaintiffs' counsel and the facility's staff. In all visits to any facility pursuant to this Agreement, Plaintiffs' counsel and their associated experts shall treat minors and staff with courtesy and dignity and shall not disrupt the normal functioning of the facility.

XIII TRAINING

34. Within 120 days of final court approval of this Agreement, the INS shall provide appropriate guidance and training for designated INS employees regarding the terms of this Agreement. The INS shall develop written and/or audio or video materials for such training. Copies of such written and/or audio or video training materials shall be made available to Plaintiffs' counsel when such training materials are sent to the field, or to the extent practicable, prior to that time.

XIV DISMISSAL

35. After the court has determined that the INS is in substantial compliance with this Agreement and the Coordinator has filed a final report, the court, without further notice, shall dismiss this action. Until such dismissal, the court shall retain jurisdiction over this action.

XV RESERVATION OF RIGHTS

36. Nothing in this Agreement shall limit the rights, if any, of individual class members to preserve issues for judicial review in the appeal of an individual case or for class members to exercise any independent rights they may otherwise have.

XVI NOTICE AND DISPUTE RESOLUTION

37. This paragraph provides for the enforcement, in this District Court, of the provisions of this Agreement except for claims brought under Paragraph 24. The parties shall meet telephonically or in person to discuss a complete or partial repudiation of this Agreement or any alleged non-compliance with the terms of the Agreement, prior to bringing any individual or class action to enforce this Agreement. Notice of a claim that a party has violated the terms of this Agreement shall be served on plaintiffs addressed to:

/ / /

CENTER FOR HUMAN RIGHTS & CONSTITUTIONAL LAW
Carlos Holguín
Peter A. Schey
256 South Occidental Boulevard
Los Angeles, CA 90057

NATIONAL CENTER FOR YOUTH LAW
Alice Bussiere
James Morales
114 Sansome Street, Suite 905
San Francisco, CA 94104

and on Defendants addressed to:

Michael Johnson
Assistant United States Attorney
300 N. Los Angeles St., Rm. 7516
Los Angeles, CA 90012

Allen Hausman
Office of Immigration Litigation
Civil Division
U.S. Department of Justice
P.O. Box 878, Ben Franklin Station
Washington, DC 20044

XVII PUBLICITY

38. Plaintiffs and Defendants shall hold a joint press conference to announce this Agreement. The INS shall send copies of this Agreement to social service and voluntary agencies agreed upon by the parties, as set forth in Exhibit 5 attached. The parties shall pursue such other public dissemination of information regarding this Agreement as the parties shall agree.

XVIII ATTORNEYS' FEES AND COSTS

39. Within 60 days of final court approval of this Agreement, Defendants shall pay to Plaintiffs the total sum of \$374,110.09, in full settlement of all attorneys' fees and costs in this case.

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XIX TERMINATION

40. All terms of this Agreement shall terminate the earlier of five years after the date of final court approval of this Agreement or three years after the court determines that the INS is in substantial compliance with this Agreement, except that the INS shall continue to house the general population of minors in INS custody in facilities that are licensed for the care of dependent minors.

XX REPRESENTATIONS AND WARRANTY

41. Counsel for the respective parties, on behalf of themselves and their clients, represent that they know of nothing in this Agreement that exceeds the legal authority of the parties or is in violation of any law. Defendants' counsel represent and warrant that they are fully authorized and empowered to enter into this Agreement on behalf of the Attorney General, the United States Department of Justice, and the Immigration and Naturalization Service, and acknowledge that Plaintiffs enter into this Agreement in reliance on such representation. Plaintiffs' counsel represent and warrant that they are fully authorized and empowered to enter into this Agreement on behalf of the Plaintiffs, and acknowledge that Defendants enter into this Agreement in reliance on such representation. The undersigned, by their signatures on behalf of the Plaintiffs and Defendants, warrant that upon execution of this Agreement in their representative capacities, their principals, agents, and successors of such principals and agents shall be fully and unequivocally bound hereunder to the full extent authorized by law.

For Defendants: Signed: Louis Meissner Title: Commissioner, INS

Dated: 7/16/96

For Plaintiffs: Signed: per next page Title: _____

Dated: _____

The foregoing stipulated settlement is approved as to form and content:

CENTER FOR HUMAN RIGHTS AND
CONSTITUTIONAL LAW

Carlos Holguin
Peter Schey

NATIONAL CENTER FOR YOUTH LAW

Alice Bussiere
James Morales

ACLU FOUNDATION OF SOUTHERN CALIFORNIA

Mark Rosenbaum
Sylvia Argueta

STEICH LANG

Susan G. Boswell
Jeffery Willis

Date: 1/13/97

By 

Date: 11/13/96

By 

Exhibit 1

EXHIBIT 1

MINIMUM STANDARDS FOR LICENSED PROGRAMS

A. Licensed programs shall comply with all applicable state child welfare laws and regulations and all state and local building, fire, health and safety codes and shall provide or arrange for the following services for each minor in its care:

1. Proper physical care and maintenance, including suitable living accommodations, food, appropriate clothing, and personal grooming items.
2. Appropriate routine medical and dental care, family planning services, and emergency health care services, including a complete medical examination (including screening for infectious disease) within 48 hours of admission, excluding weekends and holidays, unless the minor was recently examined at another facility; appropriate immunizations in accordance with the U.S. Public Health Service (PHS), Center for Disease Control; administration of prescribed medication and special diets; appropriate mental health interventions when necessary.
3. An individualized needs assessment which shall include: (a) various initial intake forms; (b) essential data relating to the identification and history of the minor and family; (c) identification of the minors' special needs including any specific problem(s) which appear to require immediate intervention; (d) an educational assessment and plan; (e) an assessment of family relationships and interaction with adults, peers and authority figures; (f) a statement of religious preference and practice; (g) an assessment of the minor's personal goals, strengths and weaknesses; and (h) identifying information regarding immediate family members, other relatives, godparents or friends who may be

residing in the United States and may be able to assist in family reunification.

4. Educational services appropriate to the minor's level of development, and communication skills in a structured classroom setting, Monday through Friday, which concentrates primarily on the development of basic academic competencies and secondarily on English Language Training (ELT). The educational program shall include instruction and educational and other reading materials in such languages as needed. Basic academic areas should include Science, Social Studies, Math, Reading, Writing and Physical Education. The program shall provide minors with appropriate reading materials in languages other than English for use during the minor's leisure time.
5. Activities according to a recreation and leisure time plan which shall include daily outdoor activity, weather permitting, at least one hour per day of large muscle activity and one hour per day of structured leisure time activities (this should not include time spent watching television). Activities should be increased to a total of three hours on days when school is not in session.
6. At least one (1) individual counseling session per week conducted by trained social work staff with the specific objectives of reviewing the minor's progress, establishing new short term objectives, and addressing both the developmental and crisis-related needs of each minor.
7. Group counseling sessions at least twice a week. This is usually an informal process and takes place with all the minors present. It is a time when new minors are given the opportunity to get acquainted with the staff, other children, and the rules of the program. It is an open forum where everyone gets a chance to speak. Daily program management

is discussed and decisions are made about recreational activities, etc. It is a time for staff and minors to discuss whatever is on their minds and to resolve problems.

8. Acculturation and adaptation services which include information regarding the development of social and inter-personal skills which contribute to those abilities necessary to live independently and responsibly.
9. Upon admission, a comprehensive orientation regarding program intent, services, rules (written and verbal), expectations and the availability of legal assistance.
10. Whenever possible, access to religious services of the minor's choice.
11. Visitation and contact with family members (regardless of their immigration status) which is structured to encourage such visitation. The staff shall respect the minor's privacy while reasonably preventing the unauthorized release of the minor.
12. A reasonable right to privacy, which shall include the right to: (a) wear his or her own clothes, when available; (b) retain a private space in the residential facility, group or foster home for the storage of personal belongings; (c) talk privately on the phone, as permitted by the house rules and regulations; (d) visit privately with guests, as permitted by the house rules and regulations; and (e) receive and send uncensored mail unless there is a reasonable belief that the mail contains contraband.
13. Family reunification services designed to identify relatives in the United States as well as in foreign countries and assistance in obtaining legal guardianship when necessary for the release of the minor.
14. Legal services information regarding the availability of free legal assistance, the right to be represented by counsel at no expense to the government, the right to a deportation or

exclusion hearing before an immigration judge, the right to apply for political asylum or to request voluntary departure in lieu of deportation.

B. Service delivery is to be accomplished in a manner which is sensitive to the age, culture, native language and the complex needs of each minor.

C. Program rules and discipline standards shall be formulated with consideration for the range of ages and maturity in the program and shall be culturally sensitive to the needs of alien minors. Minors shall not be subjected to corporal punishment, humiliation, mental abuse, or punitive interference with the daily functions of living, such as eating or sleeping. Any sanctions employed shall not: (1) adversely affect either a minor's health, or physical or psychological well-being; or (2) deny minors regular meals, sufficient sleep, exercise, medical care, correspondence privileges, or legal assistance.

D. A comprehensive and realistic individual plan for the care of each minor must be developed in accordance with the minor's needs as determined by the individualized need assessment. Individual plans shall be implemented and closely coordinated through an operative case management system.

E. Programs shall develop, maintain and safeguard individual client case records. Agencies and organizations are required to develop a system of accountability which preserves the confidentiality of client information and protects the records from unauthorized use or disclosure.

F. Programs shall maintain adequate records and make regular reports as required by the INS that permit the INS to monitor and enforce this order and other requirements and standards as the INS may determine are in the best interests of the minors.

EXHIBIT 2

INSTRUCTIONS TO SERVICE OFFICERS RE:
PROCESSING, TREATMENT, AND PLACEMENT OF MINORS

These instructions are to advise Service officers of INS policy regarding the way in which minors in INS custody are processed, housed and released. These instructions are applicable nationwide and supersede all prior inconsistent instructions regarding minors.

(a) Minors. A minor is a person under the age of eighteen years. However, individuals who have been “emancipated” by a state court or convicted and incarcerated for a criminal offense as an adult are not considered minors. Such individuals must be treated as adults for all purposes, including confinement and release on bond.

Similarly, if a reasonable person would conclude that an individual is an adult despite his claims to be a minor, the INS shall treat such person as an adult for all purposes, including confinement and release on bond or recognizance. The INS may require such an individual to submit to a medical or dental examination conducted by a medical professional or to submit to other appropriate procedures to verify his or her age. If the INS subsequently determines that such an individual is a minor, he or she will be treated as a minor for all purposes.

(b) General policy. The INS treats, and will continue to treat minors with dignity, respect and special concern for their particular vulnerability. INS policy is to place each detained minor in the least restrictive setting appropriate to the minor's age and special needs, provided that such setting is consistent with the need to ensure the minor's timely appearance and to protect the minor's well-being and that of others. INS officers are not required to release a minor to any person or agency whom they have reason to believe may harm or neglect the minor or fail to present him or her before the INS or the immigration courts when requested to do so.

(c) Processing. The INS will expeditiously process minors and will provide a Form I-770 notice of rights, including the right to a bond redetermination hearing, if applicable.

Following arrest, the INS will hold minors in a facility that is safe and sanitary and that is consistent with the INS's concern for the particular vulnerability of minors. Such facilities will have access to toilets and sinks, drinking water and food as appropriate, medical assistance if the minor is in need of emergency services, adequate temperature control and ventilation, adequate supervision to protect minors from others, and contact with family members who were arrested with the minor. The INS will separate unaccompanied minors from unrelated adults whenever possible. Where such segregation is not immediately possible, an unaccompanied minor will not be detained with an unrelated adult for more than 24 hours.

If the juvenile cannot be immediately released, and no licensed program (described below) is available to care for him, he should be placed in an INS or INS-contract facility that has separate accommodations for minors, or in a State or county juvenile detention facility that separates minors in

INS custody from delinquent offenders. The INS will make every effort to ensure the safety and well-being of juveniles placed in these facilities.

(d) Release. The INS will release minors from its custody without unnecessary delay, unless detention of a juvenile is required to secure her timely appearance or to ensure the minor's safety or that of others. Minors shall be released, in the following order of preference, to:

- (i) a parent;
- (ii) a legal guardian;
- (iii) an adult relative (brother, sister, aunt, uncle, or grandparent);
- (iv) an adult individual or entity designated by the parent or legal guardian as capable and willing to care for the minor's well-being in (i) a declaration signed under penalty of perjury before an immigration or consular officer, or (ii) such other documentation that establishes to the satisfaction of the INS, in its discretion, that the individual designating the individual or entity as the minor's custodian is in fact the minor's parent or guardian;
- (v) a state-licensed juvenile shelter, group home, or foster home willing to accept legal custody; or
- (vi) an adult individual or entity seeking custody, in the discretion of the INS, when it appears that there is no other likely alternative to long term detention and family reunification does not appear to be a reasonable possibility.

(e) Certification of custodian. Before a minor is released, the custodian must execute an Affidavit of Support (Form I-134) and an agreement to:

- (i) provide for the minor's physical, mental, and financial well-being;
- (ii) ensure the minor's presence at all future proceedings before the INS and the immigration court;
- (iii) notify the INS of any change of address within five (5) days following a move;
- (iv) if the custodian is not a parent or legal guardian, not transfer custody of the minor to another party without the prior written permission of the District Director, except in the event of an emergency;
- (v) notify the INS at least five days prior to the custodian's departing the United States of such departure, whether the departure is voluntary or pursuant to a grant of voluntary departure or order of deportation; and

(vi) if dependency proceedings involving the minor are initiated, notify the INS of the initiation of a such proceedings and the dependency court of any deportation proceedings pending against the minor.

In an emergency, a custodian may transfer temporary physical custody of a minor prior to securing permission from the INS, but must notify the INS of the transfer as soon as is practicable, and in all cases within 72 hours. Examples of an "emergency" include the serious illness of the custodian, destruction of the home, etc. In all cases where the custodian seeks written permission for a transfer, the District Director shall promptly respond to the request.

The INS may terminate the custody arrangements and assume legal custody of any minor whose custodian fails to comply with the agreement. However, custody arrangements will not be terminated for minor violations of the custodian's obligation to notify the INS of any change of address within five days following a move.

(f) Suitability assessment. An INS officer may require a positive suitability assessment prior to releasing a minor to any individual or program. A suitability assessment may include an investigation of the living conditions in which the minor is to be placed and the standard of care he would receive, verification of identity and employment of the individuals offering support, interviews of members of the household, and a home visit. The assessment will also take into consideration the wishes and concerns of the minor.

(g) Family reunification. Upon taking a minor into custody, the INS, or the licensed program in which the minor is placed, will promptly attempt to reunite the minor with his or her family to permit the release of the minor under Paragraph (d) above. Such efforts at family reunification will continue as long as the minor is in INS or licensed program custody and will be recorded by the INS or the licensed program in which the minor is placed.

(h) Placement in licensed programs. A "licensed program" is any program, agency or organization licensed by an appropriate state agency to provide residential, group, or foster care services for dependent children, including a program operating group homes, foster homes, or facilities for special needs minors. Exhibit 1 of the *Flores v. Reno* Settlement Agreement describes the standards required of licensed programs. Juveniles who remain in INS custody must be placed in a licensed program within three days if the minor was apprehended in an INS district in which a licensed program is located and has space available, or within five days in all other cases, except when:

- (i) the minor is an escape risk or delinquent, as defined in Paragraph (i) below;
- (ii) a court decree or court-approved settlement requires otherwise;
- (iii) an emergency or influx of minors into the United States prevents compliance, in which case all minors should be placed in licensed programs as expeditiously as possible; or
- (iv) the minor must be transported from remote areas for processing or speaks an unusual

language such that a special interpreter is required to process the minor, in which case the minor must be placed in a licensed program within five business days.

(i) Secure and supervised detention. A minor may be held in or transferred to a State or county juvenile detention facility or in a secure INS facility or INS-contracted facility having separate accommodations for minors, whenever the District Director or Chief Patrol Agent determines that the minor —

(i) has been charged with, is chargeable, or has been convicted of a crime, or is the subject of delinquency proceedings, has been adjudicated delinquent, or is chargeable with a delinquent act, unless the minor's offense is

(a) an isolated offense not within a pattern of criminal activity which did not involve violence against a person or the use or carrying of a weapon (Examples: breaking and entering, vandalism, DUI, etc.); or

(b) a petty offense, which is not considered grounds for stricter means of detention in any case (Examples: shoplifting, joy riding, disturbing the peace, etc.);

(ii) has committed, or has made credible threats to commit, a violent or malicious act (whether directed at himself or others) while in INS legal custody or while in the presence of an INS officer;

(iii) has engaged, while in a licensed program, in conduct that has proven to be unacceptably disruptive of the normal functioning of the licensed program in which he or she has been placed and removal is necessary to ensure the welfare of the minor or others, as determined by the staff of the licensed program (Examples: drug or alcohol abuse, stealing, fighting, intimidation of others, etc.);

(iv) is an escape-risk; or

(v) must be held in a secure facility for his or her own safety, such as when the INS has reason to believe that a smuggler would abduct or coerce a particular minor to secure payment of smuggling fees.

“Chargeable” means that the INS has probable cause to believe that the individual has committed a specified offense.

The term "escape-risk" means that there is a serious risk that the minor will attempt to escape from custody. Factors to consider when determining whether a minor is an escape-risk or not include, but are not limited to, whether:

(a) the minor is currently under a final order of deportation or exclusion;

(b) the minor's immigration history includes: a prior breach of a bond; a failure to appear before the INS or the immigration court; evidence that the minor is indebted to organized smugglers for his transport; or a voluntary departure or a previous removal from the United States pursuant to a final order of deportation or exclusion;

(c) the minor has previously absconded or attempted to abscond from INS custody.

The INS will not place a minor in a State or county juvenile detention facility, secure INS detention facility, or secure INS-contracted facility if less restrictive alternatives are available and appropriate in the circumstances, such as transfer to a medium security facility that provides intensive staff supervision and counseling services or transfer to another licensed program. All determinations to place a minor in a secure facility will be reviewed and approved by the regional Juvenile Coordinator.

(j) Notice of right to bond redetermination and judicial review of placement. A minor in deportation proceedings shall be afforded a bond redetermination hearing before an immigration judge in every case, unless the minor indicates on the Notice of Custody Determination form that he or she refuses such a hearing. A juvenile who is not released or placed in a licensed placement shall be provided (1) a written explanation of the right of judicial review as set out in Exhibit 6 of the *Flores v. Reno* Settlement Agreement, and (2) the list of free legal services providers compiled pursuant to INS regulations (unless previously given to the minor).

(k) Transportation and transfer. Unaccompanied minors should not be transported in vehicles with detained adults except when being transported from the place of arrest or apprehension to an INS office or where separate transportation would be otherwise impractical, in which case minors shall be separated from adults. INS officers shall take all necessary precautions for the protection of minors during transportation with adults.

When a minor is to be released, the INS will assist him or her in making transportation arrangements to the INS office nearest the location of the person or facility to whom a minor is to be released. The INS may, in its discretion, provide transportation to such minors.

Whenever a minor is transferred from one placement to another, she shall be transferred with all of her possessions and legal papers; provided, however, that if the minor's possessions exceed the amount permitted normally by the carrier in use, the possessions must be shipped to the minor in a timely manner. No minor who is represented by counsel should be transferred without advance notice to counsel, except in unusual and compelling circumstances such as where the safety of the minor or others is threatened or the minor has been determined to be an escape-risk, or where counsel has waived notice, in which cases notice must be provided to counsel within 24 hours following transfer.

(l) Periodic reporting. Statistical information on minors placed in proceedings who remain in INS custody for longer than 72 hours must be reported to the Juvenile Coordinator by all INS district offices and Border Patrol stations. Information will include: (a) biographical information, including the minor's name, date of birth, and country of birth, (b) date placed in INS custody, (c) each date placed, removed or released, (d) to whom and where placed, transferred, removed or released, (e) immigration

status, and (f) hearing dates. INS officers should also inform the Juvenile Coordinator of the reasons for placing a minor in a medium-security facility or detention facility as described in paragraph (i).

(m) Attorney-client visits by Plaintiffs' counsel. The INS will permit the lawyers for the *Flores v. Reno* plaintiff class to visit minors, even though they may not have the names of minors who are housed at a particular location. A list of Plaintiffs' counsel entitled to make attorney-client visits with minors is available from the district Juvenile Coordinator. Attorney-client visits may also be conducted by any staff attorney employed by the Center for Human Rights & Constitutional Law of Los Angeles, California, or the National Center for Youth Law of San Francisco, California, provided that such attorney presents credentials establishing his or her employment prior to any visit.

Visits must occur in accordance with generally applicable policies and procedures relating to attorney-client visits at the facility in question. Upon Plaintiffs' counsel's arrival at a facility for attorney-client visits, the facility staff must provide Plaintiffs' counsel with a list of names and alien registration numbers for the minors housed at that facility. In all instances, in order to memorialize any visit to a minor by Plaintiffs' counsel, Plaintiffs' counsel must file a notice of appearance with the INS prior to any attorney-client meeting. Plaintiffs' counsel may limit the notice of appearance to representation of the minor in connection with his placement or treatment during INS custody. Plaintiffs' counsel must submit a copy of the notice of appearance by hand or by mail to the local INS juvenile coordinator and a copy by hand to the staff of the facility.

A minor may refuse to meet with Plaintiffs' counsel. Further, the minor's parent or legal guardian may deny Plaintiffs' counsel permission to meet with the minor.

(n) Visits to licensed facilities. In addition to the attorney-client visits, Plaintiffs' counsel may request access to a licensed program's facility (described in paragraph (h)) or to a medium-security facility or detention facility (described in paragraph (i)) in which a minor has been placed. The district juvenile coordinator will convey the request to the facility's staff and coordinate the visit. The rules and procedures to be followed in connection with such visits are set out in Exhibit 4 of the *Flores v. Reno* Settlement Agreement, unless Plaintiffs' counsel and the facility's staff agree otherwise. In all visits to any facility, Plaintiffs' counsel and their associated experts must treat minors and staff with courtesy and dignity and must not disrupt the normal functioning of the facility.

EXHIBIT 3

CONTINGENCY PLAN

In the event of an emergency or influx that prevents the prompt placement of minors in licensed programs with which the Community Relations Service has contracted, INS policy is to make all reasonable efforts to place minors in programs licensed by an appropriate state agency as expeditiously as possible. An "emergency" is an act or event, such as a natural disaster (e.g. earthquake, fire, hurricane), facility fire, civil disturbance, or medical emergency (e.g. a chicken pox epidemic among a group of minors) that prevents the prompt placement of minors in licensed facilities. An "influx" is defined as any situation in which there are more than 130 minors in the custody of the INS who are eligible for placement in licensed programs.

1. The Juvenile Coordinator will establish and maintain an Emergency Placement List of at least 80 beds at programs licensed by an appropriate state agency that are potentially available to accept emergency placements. These 80 placements would supplement the 130 placements that the INS normally has available, and whenever possible, would meet all standards applicable to juvenile placements the INS normally uses. The Juvenile Coordinator may consult with child welfare specialists, group home operators, and others in developing the List. The Emergency Placement List will include the facility name; the number of beds potentially available at the facility; the name and telephone number of contact persons; the name and telephone number of contact persons for nights, holidays, and weekends if different; any restrictions on minors accepted (e.g. age); and any special services that are available.

2. The Juvenile Coordinator will maintain a list of minors affected by the emergency or influx, including (1) the minor's name, (2) date and country of birth, (3) date placed in INS custody, and (4)

place and date of current placement.

3. Within one business day of the emergency or influx the Juvenile Coordinator or his or her designee will contact the programs on the Emergency Placement List to determine available placements. As soon as available placements are identified, the Juvenile Coordinator will advise appropriate INS staff of their availability. To the extent practicable, the INS will attempt to locate emergency placements in geographic areas where culturally and linguistically appropriate community services are available.

4. In the event that the number of minors needing emergency placement exceeds the available appropriate placements on the Emergency Placement List, the Juvenile Coordinator will work with the Community Relations Service to locate additional placements through licensed programs, county social services departments, and foster family agencies.

5. Each year the INS will reevaluate the number of regular placements needed for detained minors to determine whether the number of regular placements should be adjusted to accommodate an increased or decreased number of minors eligible for placement in licensed programs. However, any decision to increase the number of placements available shall be subject to the availability of INS resources. The Juvenile Coordinator shall promptly provide Plaintiffs' counsel with any reevaluation made by INS pursuant to this paragraph.

6. The Juvenile Coordinator shall provide to Plaintiffs' counsel copies of the Emergency Placement List within six months after the court's final approval of the Settlement Agreement.

EXHIBIT 4

AGREEMENT CONCERNING FACILITY VISITS UNDER PARAGRAPH 33

The purpose of facility visits under paragraph 33 is to interview class members and staff and to observe conditions at the facility. Visits under paragraph 33 shall be conducted in accordance with the generally applicable policies and procedures of the facility to the extent that those policies and procedures are consistent with this Exhibit.

Visits authorized under paragraph 33 shall be scheduled no less than seven (7) business days in advance. The names, positions, credentials, and professional association (e.g., Center for Human Rights and Constitutional Law) of the visitors will be provided at that time.

All visits with class members shall take place during normal business hours.

No video recording equipment or cameras of any type shall be permitted. Audio recording equipment shall be limited to hand-held tape recorders.

The number of visitors will not exceed six (6) or, in the case of a family foster home, four (4), including interpreters, in any instance. Up to two (2) of the visitors may be non-attorney experts in juvenile justice and/or child welfare.

No visit will extend beyond three (3) hours per day in length. Visits shall minimize disruption to the routine that minors and staff follow.

EXHIBIT 5

LIST OF ORGANIZATIONS TO RECEIVE INFORMATION RE: SETTLEMENT AGREEMENT

Eric Cohen, Immig. Legal Resource Center, 1663 Mission St. Suite 602, San Francisco, CA 94103

Cecilia Munoz, Nat'l Council Of La Raza, 810 1st St. NE Suite 300, Washington, D.C. 20002

Susan Alva, Immig. & Citiz. Proj Director, Coalition For Humane Immig Rights of LA, 1521 Wilshire Blvd., Los Angeles, CA 90017

Angela Cornell, Albuquerque Border Cities Proj., Box 35895, Albuquerque, NM 87176-5895

Beth Persky, Executive Director, Centro De Asuntos Migratorios, 1446 Front Street, Suite 305, San Diego, CA 92101

Dan, Kesselbrenner, , National Lawyers Guild, National Immigration Project, 14 Beacon St.,#503, Boston, MA 02108

Lynn Marcus , SWRRP, 64 E. Broadway, Tucson, AZ 85701-1720

Maria Jimenez, , American Friends Service Cmte., ILEMP, 3522 Polk Street, Houston, TX 77003-4844

Wendy Young, , U.S. Cath. Conf., 3211 4th St. NE, , Washington, DC, 20017-1194

Miriam Hayward , International Institute Of The East Bay, 297 Lee Street , Oakland, CA 94610

Emily Goldfarb, , Coalition For Immigrant & Refugee Rights, 995 Market Street, Suite 1108 , San Francisco, CA 94103

Jose De La Paz, Director, California Immigrant Workers Association, 515 S. Shatto Place , Los Angeles, CA, 90020

Annie Wilson, LIRS, 390 Park Avenue South, First Asylum Concerns, New York, NY 10016

Stewart Kwoh, Asian Pacific American Legal Center, 1010 S. Flower St., Suite 302, Los Angeles, CA 90015

Warren Leiden, Executive Director, AILA, 1400 Eye St., N.W., Ste. 1200, Washington, DC, 20005

Frank Sharry, Nat'l Immig Ref & Citiz Forum, 220 I Street N.E., Ste. 220, Washington, D.C. 20002

Reynaldo Guerrero, Executive Director, Center For Immigrant's Rights, 48 St. Marks Place , New York, NY 10003

Charles Wheeler , National Immigration Law Center, 1102 S. Crenshaw Blvd., Suite 101 , Los Angeles, CA 90019

Deborah A. Sanders, Asylum & Ref. Rts Law Project, Washington Lawyers Comm., 1300 19th Street, N.W., Suite 500 , Washington, D.C. 20036

Stanley Mark, Asian American Legal Def.& Ed.Fund, 99 Hudson St, 12th Floor, New York, NY 10013

Sid Mohn, Executive Director, Travelers & Immigrants Aid, 327 S. LaSalle Street, Suite 1500, Chicago, IL, 60604

Bruce Goldstein, Attornet At Law, Farmworker Justice Fund, Inc., 2001 S Street, N.W., Suite 210, Washington, DC 20009

Ninfa Krueger, Director, BARCA, 1701 N. 8th Street, Suite B-28, McAllen, TX 78501

John Goldstein, , Proyecto San Pablo, PO Box 4596,, Yuma, AZ 85364

Valerie Hink, Attorney At Law, Tucson Ecumenical Legal Assistance, P.O. Box 3007 , Tucson, AZ 85702

Pamela Mohr, Executive Director, Alliance For Children's Rights, 3708 Wilshire Blvd. Suite 720, Los Angeles, CA 90010

Pamela Day, Child Welfare League Of America, 440 1st St. N.W., , Washington, DC 20001

Susan Lydon, Esq., Immigrant Legal Resource Center, 1663 Mission St. Ste 602, San Francisco, CA 94103

Patrick Maher, Juvenile Project, Centro De Asuntos Migratorios, 1446 Front Street, # 305, San Diego, CA 92101

Lorena Munoz, Staff Attorney, Legal Aid Foundation of LA-IRO, 1102 Crenshaw Blvd., Los Angeles, CA 90019

Christina Zawisza, Staff Attorney, Legal Services of Greater Miami, 225 N.E. 34th Street, Suite 300, Miami, FL 33137

Miriam Wright Edelman, Executive Director, Children's Defense Fund, 122 C Street N.W. 4th Floor, Washington, DC 20001

Rogelio Nunez, Executive Director, Proyecto Libertad, 113 N. First St., Harlingen, TX 78550

EXHIBIT 6
NOTICE OF RIGHT TO JUDICIAL REVIEW

“The INS usually houses persons under the age of 18 in an open setting, such as a foster or group home, and not in detention facilities. If you believe that you have not been properly placed or that you have been treated improperly, you may ask a federal judge to review your case. You may call a lawyer to help you do this. If you cannot afford a lawyer, you may call one from the list of free legal services given to you with this form.”

PROOF OF SERVICE BY MAIL

I, Sonia Fuentes, declare and say as follows:

1. I am over the age of eighteen years and am not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 256 South Occidental Boulevard, Los Angeles, California 90057, in said county and state.

2. On January __, 1997, I served the attached STIPULATED SETTLEMENT AGREEMENT on defendants in this proceeding by placing a true copy thereof in a sealed envelope addressed to their attorneys of record as follows:

Mr. Michael Johnson
Assistant U.S. Attorney
300 N. Los Angeles St. #7516
Los Angeles, CA 90012

and by then sealing said envelope and depositing the same, with postage thereon fully prepaid, in the mail at Los Angeles, California; that there is regular delivery of mail between the place of mailing and the place so addressed.

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

Executed this __th day of January, 1997, at Los Angeles, California.



///

LODGED

1 CENTER FOR HUMAN RIGHTS & CONSTITUTIONAL LAW
 2 Carlos Holguín
 3 Peter A. Schey
 4 Charles Song
 5 256 South Occidental Boulevard
 6 Los Angeles, CA 90057
 7 Telephone: (213) 388-8693; Fax: (213) 386-9484

RECEIVED 10 11 9:09
 DISTRICT COURT
 CENTRAL DISTRICT OF CALIF.

8 LATHAM & WATKINS
 9 Steven Schulman
 10 555 Eleventh St., NW, Suite 1000
 11 Washington, DC 20004
 12 Telephone: (202) 637-2184

Of counsel:

13 YOUTH LAW CENTER
 14 Alice Bussiere
 15 417 Montgomery Street, Suite 900
 16 San Francisco, CA 94104
 17 Telephone: (415) 543-3379 x 3903

Attorneys for plaintiffs

18 UNITED STATES DISTRICT COURT
 19 CENTRAL DISTRICT OF CALIFORNIA

20	JENNY LISETTE FLORES, et al ,)	Case No. CV 85-4544-RJK(Px)
21)	
22	Plaintiffs,)	STIPULATION EXTENDING
23)	SETTLEMENT AGREEMENT AND FOR
24	-vs-)	OTHER PURPOSES; AND ORDER
25)	THEREON
26	JANET RENO, Attorney General)	
27	of the United States, et al.)	
28)	
	Defendants)	

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IT IS HEREBY STIPULATED by and between the parties as follows:

1. Paragraph 40 of the Stipulation filed herein on January 17, 1997, is modified to read as follows:

~~“All terms of this Agreement shall terminate the earlier of five years after the date of final court approval of this Agreement or three years after the court determines that the INS is in substantial compliance with this Agreement, 45 days following defendants’ publication of final regulations implementing this Agreement~~
~~except that~~ Notwithstanding the foregoing, the INS shall continue to house the general population of minors in INS custody in facilities that are state-licensed for the care of dependent minors.”

///

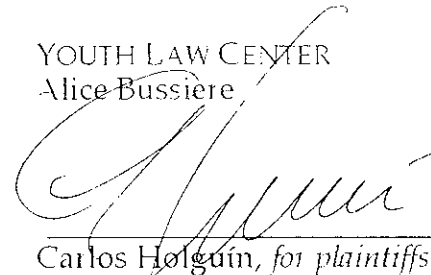
2 For a period of six months from the date this Stipulation is filed, plaintiffs shall not
initiate legal proceedings to compel publication of final regulations implementing this
Agreement. Plaintiffs agree to work with defendants cooperatively toward resolving
disputes regarding compliance with the Settlement. The parties agree to confer regularly no
less frequently than once monthly for the purpose of discussing the implementation of and
compliance with the settlement agreement. However, nothing herein shall require plaintiffs
to forebear legal action to compel compliance with this Agreement where plaintiff class
members are suffering irreparable injury

Dated: December 7, 2001.

CENTER FOR HUMAN RIGHTS &
CONSTITUTIONAL LAW
Carlos Holguín
Peter A. Schey

LATHAM & WATKINS
Steven Schulman

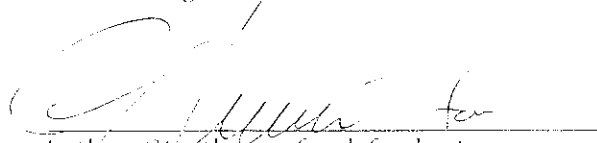
YOUTH LAW CENTER
Alice Bussiere



Carlos Holguín, for plaintiffs.

Dated: December 7, 2001

Arthur Strathern
Office of the General Counsel
U.S. Immigration & Naturalization Service



Arthur Strathern, for defendants
Per fax authorization

IT IS SO ORDERED

Dated: December _____ 2001

UNITED STATES DISTRICT JUDGE

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2 For a period of six months from the date this Stipulation is filed, plaintiffs shall not initiate legal proceedings to compel publication of final regulations implementing this Agreement. Plaintiffs agree to work with defendants cooperatively toward resolving disputes regarding compliance with the Settlement. The parties agree to confer regularly no less frequently than once monthly for the purpose of discussing the implementation of and compliance with the settlement agreement. However, nothing herein shall require plaintiffs to forebear legal action to compel compliance with this Agreement where plaintiff class members are suffering irreparable injury.

Dated: December 7, 2001.

CENTER FOR HUMAN RIGHTS &
CONSTITUTIONAL LAW
Carlos Holguín
Peter A. Schey

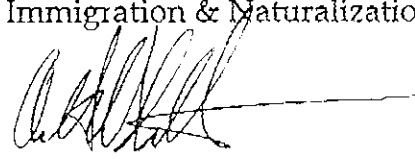
LATHAM & WATKINS
Steven Schulman

YOUTH LAW CENTER
Alice Bussiere

Carlos Holguín, *for plaintiffs*

Dated: December 7, 2001.

Arthur Strathern
Office of the General Counsel
U.S. Immigration & Naturalization Service



Arthur Strathern, *for defendants*
Per fax authorization

IT IS SO ORDERED

Dated: December 7, 2001.

UNITED STATES DISTRICT JUDGE

PROOF OF SERVICE BY MAIL.

I, Carlos Holguin, declare and say as follows:

1 I am over the age of eighteen years and am not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 256 South Occidental Boulevard, Los Angeles, California 90057, in said county and state

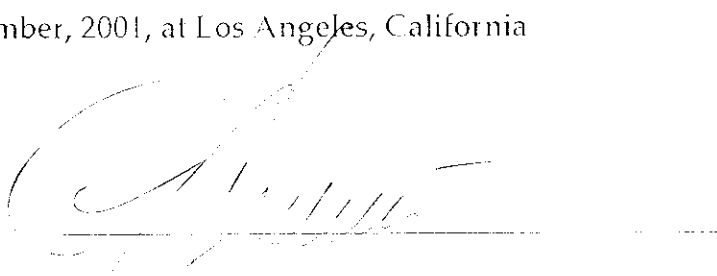
2 On December 7, 2001, I served the attached STIPULATION on defendants in this proceeding by placing a true copy thereof in a sealed envelope addressed to their attorneys of record as follows:

Arthur Strathern
Office of the General Counsel
U.S. Immigration & Naturalization Service
425 I St. N.W.
Washington, DC 20536

and by then sealing said envelope and depositing the same, with postage thereon fully prepaid, in the mail at Los Angeles, California; that there is regular delivery of mail between the place of mailing and the place so addressed.

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

Executed this 7th day of December, 2001, at Los Angeles, California



///

DECLARATION OF RACHEL PEARSON

I, Rachel Pearson, swearing under penalties of perjury, make the following declaration:

1. I am a Board-certified pediatrician who specializes in the care of hospitalized children. I hold an MD and a PhD from the University of Texas Medical Branch, and I completed three years of training in the specialty of pediatrics at Seattle Children's Hospital. I am an Assistant Professor of Pediatrics in the Division of Inpatient Pediatrics at UT Health San Antonio as well as an Assistant Professor at UT Health's Center for Medical Humanities and Ethics.
2. In my medical judgment, the conditions of immigrant detention put children at a high risk for contracting infectious diseases such as the coronavirus that causes COVID-19. Furthermore, housing detained families in close quarters violates Centers for Disease Control (CDC) recommendations for social distancing and increases the risk for spread of COVID-19 in the larger community.
3. On February 27, 2020, physician-researchers writing in the *New England Journal of Medicine* described the detention centers as "tinderboxes for infectious disease outbreaks." Researchers point to crowded conditions, a lack of adequate facilities for handwashing and showering, inadequate medical care and the harm done by chronic stress to detainees' immune systems as factors that make detention centers likely to experience outbreaks.
4. In 2019, thousands of detained migrants did require quarantine during outbreaks of influenza, mumps, and chicken pox. The COVID-19 virus can travel through the air in droplets of saliva and can survive on surfaces such as doorknobs and tables.
5. Family detention puts the larger community at risk not only because infected children may pass the virus to fellow detainees, guards and others within the facility, but also because they may require hospitalization. The largest study to date of pediatric COVID-19 infections, released by the journal *Pediatrics* on March 16, 2020, showed that 6% of infected children required hospitalization, and 11% of infants under 1 year of age required hospitalization. The virus infects children's lungs, causing pneumonia; as their oxygen levels drop, they can be at risk for death without oxygen therapy in a hospital. In this country, children have already been hospitalized for COVID-19.
6. For detained children, accessing pediatric hospital services requires triage in the detention center, transport to a local medical facility, and further transport to a facility with pediatric hospital care. Each point of contact between patients infected with COVID-19 and the healthcare system puts healthcare workers and community members at risk of infection. Furthermore, both hospital beds and medical transport

could become scarce resources in the weeks to come, putting infected children at further risk of worsening or dying as they await transport.

7. The American Academy of Pediatrics has repeatedly affirmed that immigrant detention is fundamentally unhealthy for children, and that no amount of detention is safe for a child. In my medical judgment, continuing to detain children and families during the current pandemic increases the risk of COVID-19 infections both among detainees and in the larger community.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 21, 2020
San Antonio, Texas



Rachel Pearson, MD PhD FAAP

Rachel Pearson
RachelMPearson@gmail.com
831 W Woodlawn
San Antonio, TX 78212
Cell: 512-786-1847

FACULTY APPOINTMENT

2019 **Assistant Professor of Pediatrics, Department of Pediatric Hospital Medicine**
University of Texas Health Science Center at San Antonio

Assistant Professor of Medical Humanities
Center for Medical Humanities and Ethics, UT Health San Antonio

EDUCATION

2016-2019 **Seattle Children’s Hospital, University of Washington**
Resident physician, pediatrics

2009-2016 **University of Texas Medical Branch, Institute for the Medical Humanities**
Combined MD/PhD Program
Hable Hispanic Health Care Track

2001-2006 **University of Texas at Austin**
Bachelor of Arts, Plan 2 Honors Program
cum laude, Phi Beta Kappa

RESEARCH

2018 **Project Title: Quality Improvement in Resident Communication Training**
Designing and conducting semi-structured interviews to contribute to a quality-improvement project in training pediatrics residents to break serious news.

2012-2016 **Dissertation Title: “Medical Objectivity: The Narratives that Structure Knowledge and Identity in Medicine”**
Project Description: multi-disciplinary project that distinguishes medical from scientific objectivity and proposes clinical interventions to reduce the effects of racial bias on quality of care.

2010-2011 **Project Title: Characterizing the Health Effects of Family Detention**
Project Description: Community-based collaboration with Grassroots Leadership,

the Austin Immigrant Rights Coalition, and asylum-seeking Central American families. Correlating immigrants' health narratives with existing research to characterize and quantify the health effects of family detention.

PEER REVIEWED PUBLICATIONS

- Pending **“To Combat Bias in Care, we Must Understand the Self: A Humanities-Based Critique of Medical Objectivity”**
- Pending **“Stress, Strength and Community in Memoirs of Medical Students and Residents of Color”**
- Pending **“Shaking Hands, Female Hips, and Fainting in Anatomy Lab: The Body as a Threat to Medical Student Professional Identity-Formation”**
- 2014 **“Inadvertent Stigmatization of Mental Disorders in a Primary Care Setting”**
(Austin, TX: Texas Medicine)
Humanities-based interventions to reduce stigma for mentally ill patients in primary care clinics

ORAL AND POSTER PRESENTATIONS

- 2020 **“Physician-Writers and Politics”**
Health Humanities Consortium (Nasville, TN)
- 2020 **“Mobilizing Stories for Advocacy: Law, Ethics and Policy for Physician-Writers”**
Beyond Flexner 2020 (Pheonix, AZ)
- 2018 **“Micro-Resistance in Primary Care: Toward a Radical Welcome”**
GLOCAL, Houston Global Health Collaborative (Houston, TX)
- 2015 **“Cultivating Healers: A Creative Re-Imagining of the Medical Self”**
American Society for Bioethics and Humanities (Houston, TX)
- 2015 **“Becoming A Monster: Objectivity and Objectification in Memoirs of Hospital Wards Training,”**
American Society for Bioethics and Humanities (Houston, TX)
- 2014 **“The Health Effects of Immigrant Family Detention: What Pediatricians Need to Know”**
Texas Chapter of the American Academy of Pediatrics (Austin, TX)
- 2014 **“Can Empathetic Physicians Have Aequanimitas?”**
UTMB Osler Club (Galveston TX)

Rachel Pearson

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- 2014 **“Power and Moral Distress at UTMB: A Community Conversation”**
UTMB President’s Cabinet / Students Together for Service (Galveston, TX)
- 2014 **“Aequanimitas and Grief of Mind: The Roman Roots of Oslerian Practice”**
American Osler Society (Oxford, United Kingdom)
- 2014 **“Meaning, Empathy and Moral Distress at Student-Run Clinics,”**
Society of Student-Run Free Clinics (Nashville TN)
- 2013 **“Ethical Issues in Correctional Managed Care”**
Nursing Ethics Continuing Medical Education Seminar (Galveston, TX)
- 2013 **“Medical Ethics in Texas Prisons”**
University of Texas System MD/PhD Retreat (Austin, TX)
- 2013 **“Psychopathy and Criminal Responsibility”**
American Osler Society (Tucson, AZ)

INVITED SPEECHES

- 2019 **“No Apparent Distress”**
UT Health San Antonio (San Antonio, TX)
- 2019 **Galveston Reads**
Keynote speaker for community literacy fair (Galveston, TX)
- 2019 **Association of Departments of Family Medicine 2019 Conference**
Plenary speech and book discussion (Houston, TX)
- 2018 **Medicine and Society speaker: “No Apparent Distress”**
AAMC Learn, Lead Serve 2018 (Austin, TX)
- 2018 **“Physician Wellness on the Front Lines of Medicine”**
Plenary Speech: Shein Lecture, American Association of Directors of Psychiatry
Residency Training (New Orleans, LA)
- 2017 **“Medical Student Advocacy in Struggling Communities”**
Invited speaker, the Healthcare Foundation for Humanism in Medicine at Rutgers
New Jersey Medical School (Newark, NJ)
- 2017 **“Who We Are: Humanism in an Age of Uncertainty”**
Plenary Speech, Community Learning Day, the College of New Jersey (Ewing
Township, NJ)

SELECTED NON-PEER REVIEWED PUBLICATIONS

Rachel Pearson

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- 2019 **“What a Pediatrician Can Do for an Asylum-Seeking Child—And What She Can’t”** (New York: *The New Yorker Online*)
- 2019 **“The Durable Feeling that A Child is Always at Risk,”** (New York: *The New Yorker Online*)
- 2018 **“Among the Vitamin K ‘Anti-Vaxxers,’”** (New York: *The New York Review of Books*)
- 2018 **“The Challenge of ‘Chronic Lyme,’”** (New York: *The New York Review of Books*)
- 2018 **“As a Pediatrician, I Know There’s No Way to Jail Migrant Families Without Harming Kids,”** (Austin, TX: *The Texas Observer*)
- 2017 **“Seeing the Body”** (Austin, TX: *Texas Monthly*)
- 2017 **“Four Timely Memoirs from the Hall of Medicine”** (New York: *The New York Times Book Review*)
- 2017 ***No Apparent Distress: A Doctor’s Coming-of-Age on the Front Lines of American Medicine*** (New York: W.W. Norton)
- 2017 **“When Doctors Can’t Afford to Feel”** (New York: *The Daily Beast*)
- 2015 **“How Doctors can Confront Racial Bias in Medicine”** (New York: *Scientific American*)
- 2015 **“Black Residents Gain Increased Access to Grocery Stores Post-Katrina”** (London, U.K.: *The Guardian*)
- 2015 **“Texas Abortion Law Ruling: Latinas More Likely to Avoid Clinics, Self-Terminate,”** (London, U.K.: *The Guardian*)
- 2014 **“Disease Threat from Immigrant Children Wildly Overstated”** (Austin, TX: *Texas Observer*)
- 2013 **“Texas’ Other Death Penalty: A Galveston Med Student Describes Life and Death in the Safety Net,”** (Austin, TX: *Texas Observer*)
- 2012 **“For an Intern on Call in Houston,”** (Alexandria, VA: *Journal of General Internal Medicine*)

TEACHING EXPERIENCE

-
- 2015 **Intro to the Medical Humanities (Teaching Assistant)**
Designed syllabus and co-taught 1-hour credit course for pre-medical Health Science Scholars students. Delivered 10 lectures. University of Texas at Austin
- 2015 **Writing as Patient Advocacy (Lecture)**
Texas Interdisciplinary Plan, University of Texas at Austin
- 2015 **Poetry Workshop for Pre-Medical Students (Workshop)**
Workshop, Joint Admissions Medical Program, UTMB
- 2014 **Physician-Poets and Poetry in Medical Care (Workshop)**
Health Science Scholars, University of Texas at Austin
- 2014 **Poetry Workshop for Pre-Medical Students (Workshop)**
Joint Admissions Medical Program, UTMB
- 2013 **Humanities, Ethics and Professionalism (Teaching Assistant)**
Led small-group discussions on ethics and humanities for second-year med students, UTMB
- 2013 **Creative Expressions Project (Graduate Student Mentor)**
Mentored medical student artists in various media, UTMB
- 2013 **Medical Ethics (Course Instructor)**
Co-designed and co-taught six-week ethics course for Joint Admissions Medical Program students, with focus on learning ethics through literature and art. UTMB
- 2011 **Community Service Learning Track (Course Director)**
Designed and facilitated lectures on indigent care, history of medicine, and medical economics for student volunteers in indigent care. UTMB

SELECTED MEDIA APPEARANCES / HEALTH ADVOCACY

- 2017 **KUOW, KUTX, WNPR, Minnesota Public Radio, etc**
Spoke on radio shows across the country about *No Apparent Distress* and health policy affecting working-class families
- 2017 **C-SPAN Book TV**
- 2015 **Public Radio International, *The World***
Interviewed about vaccination policies for immigrants to the U.S.
- 2014 **MSNBC, *The Chris Hayes Show***
Addressed myths about immigrant children bringing disease

Rachel Pearson

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- 2014 **ABC News, *Straight Talk with John McCaa***
Discussed Texas policy of detaining immigrant children
- 2014 **American Civil Liberties Union, *ACLU Podcast***
- 2014 **Pacifica Radio, *Background Briefing with Ian Masters***
- 2014 **Texas Public Radio, *Texas Matters***
- 2013 **Atlantic Media, *The Atlantic***
Interviewed for a story on Texas' refusal to expand Medicaid
- 2013 **Texas Democracy Foundation, *Observer Radio***

HONORS & AWARDS

- 2018 **Anson Jones Award, Texas Medical Association**
Award for physician-writers
- 2017 **Editor's Choice, *New York Times Book Review***
For *No Apparent Distress*, non-fiction book
- 2014 **Anson Jones Award, Texas Medical Association**
- 2013 **Dr. David C. Eiland Jr. Scholarship Award in Health Care and Humanities**
Competitive Academic Scholarship
- 2013 **Robert Harrison, M.D. Memorial M.D./Ph.D. Scholarship**
Competitive Academic Scholarship
- 2012 **Gold Humanism Honor Society**
- 2012 **Humanism in Surgery Award, UTMB Austin**
- 2010 **Osler Student Scholar, John P. McGovern Academy of Oslerian Medicine**
Award for compassionate care, professionalism, and incorporation of a sound scientific basis of care.
- 2005 **Robert C. Solomon Scholarship for Excellence in the Arts and Philosophy**
- 2005 **Academy of American Poets Award, University of Texas at Austin**

VOLUNTEER ACTIVITIES

- 2017-2018 **Founding member, *Inklings* resident reflective-writing group**
Provides reflective writing and arts-in-medicine services for resident wellness

Rachel Pearson

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gatherings, humanism in pediatrics events, and small-group sessions

2012-2016 **Assistant Deputy Web Editor**, *Journal of General Internal Medicine*

2013-2014 **Co-Director, St. Vincent's Student-Run Free Clinic** (15 hrs/wk)
Volunteer coordinator. Mentored medical, nursing and PA students.
Re-designed and ran training workshops to address social determinants of health and bias/stigma in indigent care. Coordinated primary and speciality care for complex patients. Liaison with social services, Medicaid, food pantry etc.

2012-2013 **Junior Director, St. Vincent's Student-Run Free Clinic** (8 hrs/wk)
Mentored pre-clinical students on providing technically and socially competent care to uninsured patients.

2009-2011 **Student provider, St. Vincent's Student-Run Free Clinic** (4 hrs/wk)
Provided direct care under faculty and senior student supervision.

PROFESSIONAL ORGANIZATIONS

American Society for Bioethics and Humanities
Gold Humanism Honor Society
American Academy of Pediatrics

LANGUAGES

Spanish: ALTA certified with "native-like fluency" in medical Spanish

PERSONAL INTERESTS

Reading, camping, art museums, animal sightings.

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

O.M.G., et al.,

Petitioners,

v.

Chad WOLF, Acting Secretary of the Department of
Homeland Security, et al.

Respondents.

Case No. 1:20-cv-00786

**EMERGENCY VERIFIED
PETITION FOR A WRIT OF
MANDAMUS AND
COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

DECLARATION OF ATTORNEY AMY MALDONADO

I, Amy Maldonado, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746 as follows:

1. On Wednesday, March 17, 2020, counsel for the Petitioners and I were contacted regarding the urgent situation engendered by the COVID-19 coronavirus pandemic, with insufficient precautions placing families at risk at the three family residential centers (Dilley, Berks and Karnes). We began gathering lists of potential plaintiffs.

2. On Thursday, March 18, 2020, counsel for the Petitioners and I finalized a tentative list of plaintiffs, had several planning calls, and began drafting the Petition in this case overnight. I was delegated the responsibility for complying with the Flores Settlement Agreement notice and meet and confer requirements for the minor Petitioners.

3. At 7:33 p.m. EST on the evening of Thursday, March 19, 2020, I sent an e-mail to Erez Reuveni, Assistant Director, U.S. Department of Justice Office of Immigration Litigation to notify him of the current and ongoing violations of the minor Petitioners rights under the Flores Settlement with regard to the Respondents' treatment of them under the current COVID-19 coronavirus pandemic conditions, and to notify him of the imminent litigation being drafted on an emergency basis. I stated in that e-mail that I would be faxing the required letter noticing the government of Flores violations on Friday, March 20, 2020. From that time through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21 2020, I have not received any response from Mr. Reuveni, including any auto-response that would indicate that he is out of the office or not checking his e-mail.

4. On the evening of Thursday, March 19, 2020, I contacted Sarah B. Fabian, Senior Litigation Counsel, U.S. Department of Justice Office of Immigration Litigation – District Court Section, to confer with her by telephone regarding the violations of the minor Petitioners rights under the Flores Settlement with regard to the Respondents' treatment of them under the current COVID-19 coronavirus pandemic conditions, and to notify her of the imminent litigation on an emergency basis. I was able to reach her and speak to her personally, and Ms. Fabian stated to me

that, of course, since the petition was still being drafted and had not been filed, she has not been assigned to this case. Further, she advised that she may be conflicted out of litigation related to the COVID-19 coronavirus.

5. The team of attorneys for the Petitioners has been continuously drafting the Emergency Verified Petition for Mandamus and Complaint for Declaratory and Injunctive relief and gathering facts and witness/expert declarations, as well as drafting various other motions and memoranda from that time through the present.

6. On Friday, March 20, 2020, at 11:53 a.m. I attempted to contact Assistant U.S. Attorney Christopher Hair at his office number and on his mobile. He did not answer his work phone and was unavailable per the automatic message of the wireless network.

7. On Friday, March 20, 2020, I faxed letters formally notifying the Respondents of their violations of the Flores Settlement Agreement. Because I did not receive a final list of the minor Petitioners until late that afternoon, the faxes were sent at 4:35 p.m. EST to the U.S. Department of Justice Office of Immigration Litigation (“DOJ OIL”), and at 4:36 p.m. EST to the Office of the U.S. Attorney, Civil Division, for the District of Columbia. I contemporaneously called the Office of the U.S. Attorney for the District of Columbia, was unable to get a person on the line, and left a message. From that time through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any response to my faxes or to my phone call.

8. On Saturday, March 21, 2020, based on my concern that we give the Respondents as much notice as possible of the issues we are raising in our litigation on an emergency basis, and given the telework situation due to the pandemic, at 11:33 a.m. EST I e-mailed: (a) the faxes; and (b) a copy of a March 19, 2020 letter to Congress from Dr. Scott A. Allen, MD, FACP, Professor Emeritus, University of California, School of Medicine, Medical Subject Matter Expert, CRCL, DHS and Dr. Josiah D. Rich, MD, MPH, Professor of Medicine and Epidemiology, The Warren Alpert Medical School of Brown University, Medical Subject Matter Expert, CRCL, DHS, to everyone for whom I have an e-mail address who works at DOJ OIL or the Office of the U.S. Attorney, Civil Division, for the District of Columbia. Those persons are: (1) for DOJ OIL, Erez Reuveni, Sarah Fabian, Archith Ramkumar, and Joshua Press; and (2) for the Office of the U.S. Attorney for the District of Columbia, Civil Division, Daniel F. Van Horn, Chief of the Civil Division, and AUSAs Christopher Hair, Nicole Murley, and Cara Alsterberg.

9. I inadvertently made an error in Mr. Van Horn’s e-mail address, and forwarded the original e-mail to the correct address at 11:36 a.m. EST. (without the March 19, 2020 letter to Congress). From the time that I sent the first e-mail through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any response to my e-mail.

10. On Saturday, March 21, 2020, at 11:54 a.m. EST I called DOJ OIL attorney Joshua Press on his cell phone, which I had from prior litigation. I was able to reach him and speak to him personally, and I expressed my request that he alert whoever may be the duty

attorney for the weekend for DOJ OIL regarding the imminent litigation and request for emergency relief. Mr. Press acknowledged the request.

11. On Saturday, March 21, 2020, at 5:48 p.m., I followed the directions on the website for the Office of the U.S. Attorney for the District of Columbia, Civil Division, which state “In an emergency outside normal business hours when no one can be reached at the Civil Division’s general telephone number, contact the Department of Justice Command Center at (202) 514-5000.” I spoke to “Jay.”

12. At 6:06 p.m. EST, “Jay” from the Department of Justice Command Center returned my call, indicated that he was able to contact someone in the office of the U.S. Attorney, and that he would take my cell phone number and e-mail down, and that person would reach out to me. From the time that I received that call through the signing of this declaration at approximately 8:19 p.m. EST on Saturday, March 21, 2020, I have not received any e-mail or telephone call.

13. Counsel for the Petitioners has worked tirelessly to finalize the Emergency Petition and other pleadings in this case. It was simply impossible to do so and gather the volume of expert and witness testimony that we have by the end of business on Friday, March 20, 2020.

14. I have made every effort possible to apprise the Respondents of the substance of the Petitioners’ concerns, have made every effort to reach an attorney for the Respondents, and have spoken with two DOJ OIL attorneys (Sarah Fabian and Joshua Press) who are not assigned to this matter. Upon scheduling of an emergency hearing, I will continue to make every effort to contact DOJ OIL and the Office of the U.S. Attorney for the District of Columbia, Civil Division so that they may participate.

Executed on March 21, 2020 in East Lansing, Michigan.

By: /s/ Amy Maldonado
Amy Maldonado (IL #6256961)

Amy Maldonado, Of Counsel **
ALDEA - THE PEOPLE’S JUSTICE CENTER
532 Walnut Street
Reading, PA 19601
Phone: (484) 877-8002
Fax: (484) 926-2032
Email: amy@aldeapjc.org

Attorney for Petitioners
***Application for admission pro hac vice*
forthcoming

<input type="radio"/> G. Habeas Corpus/ 2255 <input type="checkbox"/> 530 Habeas Corpus – General <input type="checkbox"/> 510 Motion/Vacate Sentence <input type="checkbox"/> 463 Habeas Corpus – Alien Detainee	<input type="radio"/> H. Employment Discrimination <input type="checkbox"/> 442 Civil Rights – Employment (criteria: race, gender/sex, national origin, discrimination, disability, age, religion, retaliation) *(If pro se, select this deck)*	<input type="radio"/> I. FOIA/Privacy Act <input type="checkbox"/> 895 Freedom of Information Act <input type="checkbox"/> 890 Other Statutory Actions (if Privacy Act) *(If pro se, select this deck)*	<input type="radio"/> J. Student Loan <input type="checkbox"/> 152 Recovery of Defaulted Student Loan (excluding veterans)
<input type="radio"/> K. Labor/ERISA (non-employment) <input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Mgmt. Relations <input type="checkbox"/> 740 Labor Railway Act <input type="checkbox"/> 751 Family and Medical Leave Act <input type="checkbox"/> 790 Other Labor Litigation <input type="checkbox"/> 791 Empl. Ret. Inc. Security Act	<input type="radio"/> L. Other Civil Rights (non-employment) <input type="checkbox"/> 441 Voting (if not Voting Rights Act) <input type="checkbox"/> 443 Housing/Accommodations <input type="checkbox"/> 440 Other Civil Rights <input type="checkbox"/> 445 Americans w/Disabilities – Employment <input type="checkbox"/> 446 Americans w/Disabilities – Other <input type="checkbox"/> 448 Education	<input type="radio"/> M. Contract <input type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 153 Recovery of Overpayment of Veteran’s Benefits <input type="checkbox"/> 160 Stockholder’s Suits <input type="checkbox"/> 190 Other Contracts <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise	<input type="radio"/> N. Three-Judge Court <input type="checkbox"/> 441 Civil Rights – Voting (if Voting Rights Act)

V. ORIGIN
 1 Original Proceeding
 2 Removed from State Court
 3 Remanded from Appellate Court
 4 Reinstated or Reopened
 5 Transferred from another district (specify)
 6 Multi-district Litigation
 7 Appeal to District Judge from Mag. Judge
 8 Multi-district Litigation – Direct File

VI. CAUSE OF ACTION (CITE THE U.S. CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE A BRIEF STATEMENT OF CAUSE.)
 28 U.S. Code § 1331, § 1361 and the Constitution; Emergency relief to detained immigrant families due to pandemic.

VII. REQUESTED IN COMPLAINT	CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23 <input type="checkbox"/>	DEMAND \$ _____	JURY DEMAND: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
VIII. RELATED CASE(S) IF ANY	(See instruction)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	If yes, please complete related case form

DATE: 03/21/2020	SIGNATURE OF ATTORNEY OF RECORD
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INSTRUCTIONS FOR COMPLETING CIVIL COVER SHEET JS-44
 Authority for Civil Cover Sheet

The JS-44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and services of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. Listed below are tips for completing the civil cover sheet. These tips coincide with the Roman Numerals on the cover sheet.

- I. COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF/DEFENDANT (b) County of residence: Use 11001 to indicate plaintiff if resident of Washington, DC, 88888 if plaintiff is resident of United States but not Washington, DC, and 99999 if plaintiff is outside the United States.
- III. CITIZENSHIP OF PRINCIPAL PARTIES: This section is completed only if diversity of citizenship was selected as the Basis of Jurisdiction under Section II.
- IV. CASE ASSIGNMENT AND NATURE OF SUIT: The assignment of a judge to your case will depend on the category you select that best represents the primary cause of action found in your complaint. You may select only one category. You must also select one corresponding nature of suit found under the category of the case.
- VI. CAUSE OF ACTION: Cite the U.S. Civil Statute under which you are filing and write a brief statement of the primary cause.
- VIII. RELATED CASE(S), IF ANY: If you indicated that there is a related case, you must complete a related case form, which may be obtained from the Clerk’s Office.

Because of the need for accurate and complete information, you should ensure the accuracy of the information provided prior to signing the form.

JS-44 CIVIL COVER SHEET, ADDENDUM

O.M.G., ET AL, V. WOLF, ET AL

1. (a) Plaintiffs/Petitioners (cont.)

R.S.J. and S.A., a minor; A.L.M. and A.M.M., a minor; G.A.Q. and minors N.N.A. and A.A.Q.; N.M.L. and A.R.M., a minor; M.R.A. and L.C.R., a minor; J.S.P. and M.A.S., a minor; K.N.E. and E.A.N., a minor; K.P.P. and minors M.P.P. and I.P.P.; M.C.M. and S.M.C., a minor; C.C.G. and E.C.G., a minor; B.C.A. and G.S.C., a minor; S.J.A. and W.A.A., a minor; O.T.G. and T.T.G., a minor; M.J.P. and minors A.M.P., A.P.P. and C.P.P.; J.C. and Y.C., a minor; C.R.R. and minors V.G.R. and I.G.R.; A.C.O. and J.S.O., a minor; M.A.M. and G.M.A., a minor; J.M.R. and C.G.M., a minor; R.P.F. and J.F.P., a minor; M.R.C. and M.E.C., a minor; B.G.C. and S.M.G., a minor; C.A.M. and A.P.A., a minor; M.A.H. and I.M.A., a minor; M.B.G., M.H.H. and A.B.H., a minor; C.V.S., S.V.S., and minors J.B.S., R.B.V., J.V.V.-1, J.V.V.-2. and N.V.V.; B.P., K.G.D. and E.P.G., a minor;; R.M. and V.P., a minor; A.R., T.F. and minors B.F.R. and D.F.R.; A.G.V., A.M.G. and minors A.G.M.-1, A.G.M.-2, and A.G.M.-3; G.R.D., B.N.P., and minors M.R.N., I.R.N., and N.R.N.; and A.A.G., L.M.V., and S.A.M, a minor.

1. (c) Attorneys for Plaintiffs/Petitioners (cont.)

Manoj Govindaiah, Curtis F.J. Doebbler
REFUGEE AND IMMIGRANT CENTER FOR EDUCATION AND LEGAL SERVICES (RAICES)
802 Kentucky Avenue, San Antonio, TX 78212
Phone: (210) 226-7722

Attorneys for Defendants/Respondents (cont.)

U.S. Department of Justice, Office of Immigration Litigation
950 Pennsylvania Avenue, NW, Washington, DC 20530-0001
Phone: (202) 514-2000

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

O.M.G. and H.G.M., a minor; C.L. and J.A., a minor;
M.C. and G.L.C., a minor; A.H.R. and J.H.R., a minor;
N.V. and Z.F., a minor; R.S.J. and S.A., a minor;
A.L.M. and A.M.M., a minor; G.A.Q. and minors
N.N.A. and A.A.Q.; (continued on Addendum)

Plaintiff(s)

v.

Chad WOLF, in his official capacity as the acting
Secretary of the U.S. Department of Homeland
Security; and William BARR, in his official capacity as
the Attorney General of the United States,

Defendant(s)

Civil Action No. 1:20-cv-00786

SUMMONS IN A CIVIL ACTION

To: (Defendant's name and address)

Chad WOLF
Acting Secretary of the U.S. Department of Homeland Security; and
Office of the General Counsel
U.S. Department of Homeland Security
Washington, D.C. 20528.

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Gregory P. Copeland
Sarah T. Gillman
RAPID DEFENSE NETWORK
11 Broadway, Suite 615
New York, NY 10004-1490

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

Signature of Clerk or Deputy Clerk

Civil Action No. 1:20-cv-00786

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____
was received by me on *(date)* _____.

I personally served the summons on the individual at *(place)* _____
_____ on *(date)* _____; or

I left the summons at the individual's residence or usual place of abode with *(name)* _____
_____, a person of suitable age and discretion who resides there,
on *(date)* _____, and mailed a copy to the individual's last known address; or

I served the summons on *(name of individual)* _____, who is
designated by law to accept service of process on behalf of *(name of organization)* _____
_____ on *(date)* _____; or

I returned the summons unexecuted because _____; or

Other *(specify)*:

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ _____ 0.00 _____.

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc:

Print

Save As...

Reset

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

Plaintiffs/Petitioners (Cont.)

N.M.L. and A.R.M., a minor; M.R.A. and L.C.R., a minor; J.S.P. and M.A.S., a minor; K.N.E. and E.A.N., a minor; K.P.P. and minors M.P.P. and I.P.P.; M.C.M. and S.M.C., a minor; C.C.G. and E.C.G., a minor; B.C.A. and G.S.C., a minor; S.J.A. and W.A.A., a minor; O.T.G. and T.T.G., a minor; M.J.P. and minors A.M.P., A.P.P. and C.P.P.; J.C. and Y.C., a minor; C.R.R. and minors V.G.R. and I.G.R.; A.C.O. and J.S.O., a minor; M.A.M. and G.M.A., a minor; J.M.R. and C.G.M., a minor; R.P.F. and J.F.P., a minor; M.R.C. and M.E.C., a minor; B.G.C. and S.M.G., a minor; C.A.M. and A.P.A., a minor; M.A.H. and I.M.A., a minor; M.B.G., M.H.H. and A.B.H., a minor; C.V.S., S.V.S., and minors J.B.S., R.B.V., J.V.V.-1, J.V.V.-2. and N.V.V.; B.P., K.G.D. and E.P.G., a minor; R.M. and V.P., a minor; A.R., T.F. and minors B.F.R. and D.F.R.; A.G.V., A.M.G. and minors A.G.M.-1, A.G.M.-2, and A.G.M.-3; G.R.D., B.N.P., and minors M.R.N., I.R.N., and N.R.N.; A.A.G., L.M.V., and S.A.M, a minor.

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

O.M.G. and H.G.M., a minor; C.L. and J.A., a minor;
M.C. and G.L.C., a minor; A.H.R. and J.H.R., a minor;
N.V. and Z.F., a minor; R.S.J. and S.A., a minor;
A.L.M. and A.M.M., a minor; G.A.Q. and minors
N.N.A. and A.A.Q.; (continued on Addendum)

Plaintiff(s)

v.

Chad WOLF, in his official capacity as the acting
Secretary of the U.S. Department of Homeland
Security; and William BARR, in his official capacity as
the Attorney General of the United States,

Defendant(s)

Civil Action No. 1:20-cv-00786

SUMMONS IN A CIVIL ACTION

To: (Defendant's name and address)

William Barr, Attorney General of the United States
Office of the Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W., Washington, D.C. 20530-0001,

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Gregory P. Copeland
Sarah T. Gillman
RAPID DEFENSE NETWORK
11 Broadway, Suite 615
New York, NY 10004-1490

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

Signature of Clerk or Deputy Clerk

Civil Action No. 1:20-cv-00786

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____
was received by me on *(date)* _____.

I personally served the summons on the individual at *(place)* _____
_____ on *(date)* _____; or

I left the summons at the individual's residence or usual place of abode with *(name)* _____
_____, a person of suitable age and discretion who resides there,
on *(date)* _____, and mailed a copy to the individual's last known address; or

I served the summons on *(name of individual)* _____, who is
designated by law to accept service of process on behalf of *(name of organization)* _____
_____ on *(date)* _____; or

I returned the summons unexecuted because _____; or

Other *(specify)*:

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ _____ 0.00 _____.

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc:

Print

Save As...

Reset

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

Plaintiffs/Petitioners (Cont.)

N.M.L. and A.R.M., a minor; M.R.A. and L.C.R., a minor; J.S.P. and M.A.S., a minor; K.N.E. and E.A.N., a minor; K.P.P. and minors M.P.P. and I.P.P.; M.C.M. and S.M.C., a minor; C.C.G. and E.C.G., a minor; B.C.A. and G.S.C., a minor; S.J.A. and W.A.A., a minor; O.T.G. and T.T.G., a minor; M.J.P. and minors A.M.P., A.P.P. and C.P.P.; J.C. and Y.C., a minor; C.R.R. and minors V.G.R. and I.G.R.; A.C.O. and J.S.O., a minor; M.A.M. and G.M.A., a minor; J.M.R. and C.G.M., a minor; R.P.F. and J.F.P., a minor; M.R.C. and M.E.C., a minor; B.G.C. and S.M.G., a minor; C.A.M. and A.P.A., a minor; M.A.H. and I.M.A., a minor; M.B.G., M.H.H. and A.B.H., a minor; C.V.S., S.V.S., and minors J.B.S., R.B.V., J.V.V.-1, J.V.V.-2. and N.V.V.; B.P., K.G.D. and E.P.G., a minor; R.M. and V.P., a minor; A.R., T.F. and minors B.F.R. and D.F.R.; A.G.V., A.M.G. and minors A.G.M.-1, A.G.M.-2, and A.G.M.-3; G.R.D., B.N.P., and minors M.R.N., I.R.N., and N.R.N.; A.A.G., L.M.V., and S.A.M, a minor.

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

O.M.G. and H.G.M., a minor; C.L. and J.A., a minor;
M.C. and G.L.C., a minor; A.H.R. and J.H.R., a minor;
N.V. and Z.F., a minor; R.S.J. and S.A., a minor;
A.L.M. and A.M.M., a minor; G.A.Q. and minors
N.N.A. and A.A.Q.; (continued on Addendum)

Plaintiff(s)

v.

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Secretary of the U.S. Department of Homeland
Security; and William BARR, in his official capacity as
the Attorney General of the United States,

Defendant(s)

Civil Action No. 1:20-cv-00786

SUMMONS IN A CIVIL ACTION

To: (Defendant's name and address)

Civil Process Clerk
United States Attorney's Office
555 Fourth Street, N.W.
Washington, D.C. 20530

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Gregory P. Copeland
Sarah T. Gillman
RAPID DEFENSE NETWORK
11 Broadway, Suite 615
New York, NY 10004-1490

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

Signature of Clerk or Deputy Clerk

Civil Action No. 1:20-cv-00786

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____
was received by me on *(date)* _____.

I personally served the summons on the individual at *(place)* _____
_____ on *(date)* _____ ; or

I left the summons at the individual's residence or usual place of abode with *(name)* _____
_____, a person of suitable age and discretion who resides there,
on *(date)* _____, and mailed a copy to the individual's last known address; or

I served the summons on *(name of individual)* _____, who is
designated by law to accept service of process on behalf of *(name of organization)* _____
_____ on *(date)* _____ ; or

I returned the summons unexecuted because _____ ; or

Other *(specify)*:

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ _____ 0.00 _____.

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc:

Print

Save As...

Reset

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

Plaintiffs/Petitioners (Cont.)

N.M.L. and A.R.M., a minor; M.R.A. and L.C.R., a minor; J.S.P. and M.A.S., a minor; K.N.E. and E.A.N., a minor; K.P.P. and minors M.P.P. and I.P.P.; M.C.M. and S.M.C., a minor; C.C.G. and E.C.G., a minor; B.C.A. and G.S.C., a minor; S.J.A. and W.A.A., a minor; O.T.G. and T.T.G., a minor; M.J.P. and minors A.M.P., A.P.P. and C.P.P.; J.C. and Y.C., a minor; C.R.R. and minors V.G.R. and I.G.R.; A.C.O. and J.S.O., a minor; M.A.M. and G.M.A., a minor; J.M.R. and C.G.M., a minor; R.P.F. and J.F.P., a minor; M.R.C. and M.E.C., a minor; B.G.C. and S.M.G., a minor; C.A.M. and A.P.A., a minor; M.A.H. and I.M.A., a minor; M.B.G., M.H.H. and A.B.H., a minor; C.V.S., S.V.S., and minors J.B.S., R.B.V., J.V.V.-1, J.V.V.-2. and N.V.V.; B.P., K.G.D. and E.P.G., a minor; R.M. and V.P., a minor; A.R., T.F. and minors B.F.R. and D.F.R.; A.G.V., A.M.G. and minors A.G.M.-1, A.G.M.-2, and A.G.M.-3; G.R.D., B.N.P., and minors M.R.N., I.R.N., and N.R.N.; A.A.G., L.M.V., and S.A.M, a minor.