UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

ROMEL AMAYA-CRUZ, JONAS NSONGI MBONGA, ELVIRA PASCALENCO, and HECTOR MANUEL REYES CRUZ,

Petitioner-Plaintiffs,

- vs. -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; and U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT,

Respondent-Defendants.

Case No. _____

PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

Plaintiffs Romel Amaya-Cruz, Jonas Nsongi Mbonga, Elvira Pascalenco, and Hector Manuel Reyes Cruz hereby move this Court, pursuant to Fed. R. Civ. P. 65, for a temporary restraining order. The Plaintiffs are medically vulnerable ICE detainees, three of whom are confined to the Geauga County Jail and one to the Seneca County Jail, who seek safe and immediate release based on their risk of serious harm or death if exposed to COVID-19. The grounds for this Motion are set forth in the attached Memorandum in Support and accompanying declarations.

Dated: April 10, 2020

Respectfully submitted,

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ROMEL AMAYA-CRUZ, JONAS NSONGI MBONGA, ELVIRA PASCALENCO, and HECTOR MANUEL REYES CRUZ,

Petitioner-Plaintiffs,

- vs. -

REBECCA ADDUCCI, in her official capacity as Detroit District Director of U.S. Immigration & Customs Enforcement; MATTHEW T. ALBENCE, in his official capacity as Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; and U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT,

Respondent-Defendants.

Case No. _____

MEMORANDUM IN SUPPORT OF PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

INTRODUCTION

Romel Amaya-Cruz, Jonas Nsongi Mbonga, Elvira Pascalenco, and Hector Manuel Reyes Cruz (collectively "Plaintiffs") are non-citizen detainees with medical conditions that make them highly vulnerable to serious illness and death from COVID-19, three of whom are being held in civil detention at the Geauga County Jail ("Geauga") and one at the Seneca County Jail ("Seneca") in violation of their Due Process rights.[1] COVID-19 is already infecting scores of immigrant detainees across the country because of the confined, congregate nature of the facilities in which immigrant detainees are held; and it is going to infect far too many more. Tragically, the virus has already reached twenty ICE detention facilities across the country—including nearby Butler County Jail in Hamilton, Ohio and St. Clair County Jail in Port Huron, Michigan. COVID-19 has no vaccine, no treatment, and no cure. It can be transmitted by people who are completely asymptomatic. By the time a person has tested positive, or even begun to feel early symptoms, they may already have infected countless other people with whom they have had contact. The only option for medically vulnerable people to avoid serious illness and death from COVID-19 is to practice both social distancing and careful hygiene. At Geauga and Seneca, because of the enclosed, close quarters in which detainees are held, it is impossible to practice either measure.

Given the nature of this pandemic, there is no way to ensure that at-risk individuals such as Plaintiffs avoid exposure to COVID-19 while they remain in detention. This near-certain exposure to a virulent, possibly deadly disease violates their constitutional rights. There is no way to protect them short of immediate release. Their release, along with adequate public health and safety measures like GPS monitoring and home quarantine and confinement, is also in the public

[1] Mr. Amaya-Cruz, Mr. Nsogni Mbonga, and Elvira Pascalenco are detained at Geauga. Mr. Reyes Cruz is detained at Seneca.

interest because contagion among the detainee population and jail staff would deplete the Geauga and Seneca County areas of limited resources, including ventilators and intensive care units.

The Court should grant Plaintiffs' motion and order their immediate release from detention.

FACTS

As of April 9, 2020, at least 395,030 people in the United States have tested positive for COVID-19, and 12,740 people in the United States have died from the disease.[2] Plaintiffs, like other individuals who are older and/or have certain medical conditions, are acutely vulnerable to grave complications or death if exposed to the disease.[3] *Id*. ¶ 6–7; Greifinger Decl. ¶ 20. People with these medical conditions who contract COVID-19 typically require advanced support, including highly specialized equipment and a team of medical providers. Amon Decl. ¶ 6–10. So long as Plaintiffs are detained at Geauga and Seneca, they cannot protect themselves; they simply cannot attain any social distance, which puts them at imminent risk of substantial bodily harm and death. Even simple hygiene products, which might help though would not resolve the grave risks, are not made available to them.

I. PLAINTIFFS ARE ESPECIALLY SUSCEPTIBLE TO AND ARE AT GRAVE RISK OF HARM FROM COVID-19.

Plaintiff Romel Amaya-Cruz (detained at Geauga) is HIV-positive and suffers from many ensuing complications, such as brain lesions (bleeding on the brain), toxoplasmosis (a parasitic infection, often found in immunocompromised patients), and toxoplasmic encephalitis (swelling of the brain caused by toxoplasma infection). Starda Decl. ¶ 7. Since entering Geauga, Mr.

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[2] Coronavirus disease 2019 (COVID-19) Situation Report – 80, World Health Organization (Apr. 8, 2020), Ngo Decl. Ex. A. Some sources have estimated that these numbers are even higher. *See* Amon Decl. ¶ 5 (citing data from Johns Hopkins University).

[3] Plaintiffs' Petition for the Writ of Habeas Corpus Pursuant to 28 U.S.C. § 2241 ("Pet.") ¶¶ 46–62.

Amaya-Cruz has had a heightened level of HIV present in his body, yet has been unable to see the physician who has normally managed his HIV medication regimen. *Id.* ¶ 7(a)–(b). Mr. Amaya-Cruz also suffers from chronic headaches, eczema, and neck pain. *Id.* ¶¶ 7, 7(c). As a result of his HIV status and other conditions, he is at a high risk for severe illness or death if he contracts COVID-19. Greifinger Decl. ¶ 20(a).

Plaintiff Jonas Nsongi Mbonga (detained at Geauga) suffers from latent tuberculosis, a condition in which certain illnesses, including the flu, can trigger active tuberculosis, a serious respiratory infection. DeVito Decl. ¶ 6(a). Mr. Nsongi Mbonga also suffers from lasting brain injuries, including chronic headaches, as a result of being assaulted and tortured by government agents in the Democratic Republic of Congo, his country of origin. *Id.* ¶¶ 4, 6(b). Mr. Nsongi Mbonga further suffers from severe abdominal pain and has been diagnosed with, among other things, gastroenteritis and amebiasia, an inflammation of the lining of the intestines caused by an intestinal virus or parasite. *Id.* ¶ 6(c). As a result of his latent tuberculosis and other conditions, he is at high risk for severe illness or death if he contracts COVID-19. Greifinger Decl. ¶ 20(b).

Plaintiff Elvira Pascalenco (detained at Geauga) is 52 years old and suffers from a number of serious medical conditions, including asthma, migraines, chronic bilateral low back pain, high cholesterol, osteoporosis, and recurrent major depressive disorder. Krncevic Decl. ¶¶ 6(a)–6(b) To control her asthma, Ms. Pascalenco has been instructed by her physician to take inhaler treatments every four hours, every day, and to take the medication Singulair every day. *Id.* ¶ 6(a). Geauga does not provide Ms. Pascalenco with the inhaler that she requires to treat her asthma. As a result of having asthma, even were it treated, she is at high risk for severe illness or death if she contracts COVID-19. Greifinger Decl. ¶ 20(c).

Plaintiff Hector Manuel Reyes Cruz (detained at Seneca) suffers from hypertension, and has had a persistent cough for which he has been unable to obtain treatment. Hoffman Decl. ¶ 8. Mr. Reyes Cruz also suffers from severely painful toothaches that continue to be left untreated, as well as anxiety and depression. *Id.* As a result of his hypertension, he is at high risk for severe illness or death if he contracts COVID-19. Greifinger Decl. ¶ 20(d).

II. DETENTION AT GEAUGA AND SENECA PUTS PLAINTIFFS AT IMMINENT RISK OF SUBSTANTIAL BODILY HARM.

The danger of COVID-19 exposure to Plaintiffs is acute at Geauga and Seneca. Infectious diseases like COVID-19, which are communicable by air and touch, are exponentially more likely to spread in "congregate environments," such as immigration detention centers.[4] Greifinger Decl. ¶¶ 8, 10; Ngo Decl. Ex. D. Social distancing combined with vigilant hygiene, including frequent washing of hands with soap and water, is the only known effective measure for protecting vulnerable people from contracting COVID-19. Amon Decl. ¶ 11; Ngo Decl. Ex. D at 4; Greifinger Decl. ¶¶ 4, 8. Recent guidance issued by the United States Immigration and Customs Enforcement ("ICE") acknowledges the risks of COVID-19 to detainees.[5] However, even if the

[4] COVID-19 has already reached nearby ICE detention facilities. As of the date of this filing, April 10, 2020, one employee at Butler County Jail in Hamilton, Ohio and one detainee at St. Clair County Jail in Port Huron, Michigan had tested positive for the virus. *See* U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (last updated Apr. 10, 2020), Ngo Decl. Ex. B. According to ICE, in total, fifty ICE detainees (across seventeen facilities in Arizona, California, Florida, Georgia, Louisiana, Michigan, New Jersey, New York, and Pennsylvania) and fifteen ICE detention center employees (across six facilities in Colorado, New Jersey, Ohio, Louisiana and Texas) have tested positive for COVID-19. *Id.* Due to lack of testing, that number is likely an undercount of the actual numbers of positive results. *See* Amon Decl. ¶5; Greifinger Decl. ¶¶ 3, 12(c). An internal ICE COVID-19 report states that, as of March 19, 2020, ICE's Health Services Corps had isolated nine detainees and it was monitoring 24 more in ten different ICE facilities, and 1,444 officials with ICE and DHS were in precautionary self-quarantine. *See* Ken Klippenstein, *Exclusive: ICE Detainees Are Being Quarantined*, The Nation (Mar. 24, 2020), Ngo Decl. Ex. C.

[5] *ICE Guidance on COVID-19* ("ICE Guidance"), U.S. Immigration & Customs Enforcement, www.ice.gov/covid19.

guidance were being followed in facilities such as Geauga and Seneca—and it is not—it would be inadequate protection; "wholly insufficient to adequately face the crisis at hand." Greifinger Decl. ¶ 12; *accord* Amon Decl. ¶ 31 ("Detention facilities were not built to implement the CDC guidance, or for the needs of this kind of pandemic.").

First, the physical structure of the Geauga and Seneca facilities makes social distancing impossible. ICE recommends that "[d]etainees who meet CDC criteria for epidemiologic risk of exposure to COVID-19 [be] housed separately from the general population," but at Geauga and Seneca, medically vulnerable individuals like Plaintiffs remain housed in the general population. Greifinger Decl. ¶ 12(g), 12(h); DeVito Decl. ¶ 8(a); Strada Decl. ¶ 9(a); Hoffman Decl. ¶ 6(a). Plaintiffs and other detained individuals are kept together in groups of up to sixty people who eat, sleep, and live in closely confined quarters. Burnett Decl. ¶¶ 8–12; DeVito Decl. ¶ 8(a); Drozda ¶ 13; Hoffman Decl.¶ 6(a). Most detainees sleep close together in cells or small communal rooms, in which they cannot avoid being well within six feet of each other; more commonly they are forced to be two or three feet apart. DeVito Decl. ¶ 8(a); Drozda ¶ 13; Strada Decl. ¶ 9(a); Hoffman Decl. ¶ 6(a). Many sleep in bunk beds shared with another person. Burnett Decl. ¶ 10. Detainees share showers and bathroom stalls with one another. Hoffman Decl.¶ 6(a)–(c) (thirty-five Seneca detainees "share the jail's 40-bed dormitory unit"); Krncevic Decl. ¶ 6(i) (observing that showers at Geauga are dirty and covered in mold, and are shared by everyone).[6] Both food preparation and service are also communal; detainees eat all meals in a communal dining hall, where they must sit closely at shared tables with multiple other people. Burnett Decl. ¶¶ 11–12;

[6] *See also* Yeganeh Torbati et al., *In a 10-Day Span, ICE Flew This Detainee Across the Country – Nine Times*, Big Easy Magazine (Mar. 30, 2020), https://www.bigeasymagazine.com/2020/03/30/in-a-10-day-span-ice-flew-this-detainee-across-the-country-nine-times/, Ngo Decl. Ex. E ("Dozens of people shared one shower and four bathroom stalls" at "the crowded Seneca County Jail.")

DeVito Decl. ¶ 8(c) (noting that at Geauga, all detainees eat in a cafeteria with tables approximately three apart from one another). At Geauga, there is very little air circulation, as detainees never have access to any outside air. Drozda Decl. ¶ 11 (stating that she has not seen any "windows to the outdoors in any of [Geauga's] internal rooms").[7] Further, although ICE recommends that "[d]etainees who meet CDC criteria for epidemiologic risk of exposure to COVID-19 [be] housed separately from the general population," at Geauga and Seneca, medically vulnerable individuals like Plaintiffs remain housed in the general population. Greifinger Decl. ¶ 12(g), 12(h); DeVito Decl. ¶ 8(a); Strada Decl. ¶ 9(a); Hoffman Decl. ¶ 6(a).

Second, because detainees are unable to maintain proper hygiene and distancing practices, it is likely that COVID-19 has already reached Geauga and Seneca and is spreading among detainees and staff. Amon Decl. ¶ 31 ("[C]onditions in immigration detention facilities do not allow individuals or staff to protect themselves and are likely to facilitate the spread of COVID-19."); *see also* Burnett Decl. ¶ 13 ("Detainees at Seneca are rarely provided with hygiene materials, other than two soap dispensers in the shared bathroom, which often run out and are rarely refilled" and "[n]o hand sanitizer is available"); DeVito Decl. ¶ 8(c) (Geauga detainees have been given neither face masks nor gloves nor any other protective equipment); Hoffman ¶ 7; Krncevic Decl.¶ 6(k). Additionally, "detainees have no way to socially distance themselves from staff members" who may be carrying the virus asymptomatically. Amon Decl. ¶ 21. Detainees have not worn protective equipment like gloves or face masks, and have rarely observed staff doing so. Burnett Decl. ¶ 16; DeVito Decl. ¶ 8(c) (Geauga guards do not wear face masks); Hoffman ¶ 7 (Seneca

[7] *See also* Noah Lanard, *A Haitian Asylum-Seeker Did Everything Right. ICE Sent Him to a Windowless Jail Cell.*, Mother Jones (Dec. 7, 2018), https://www.motherjones.com/politics/2018/12/a-haitian-asylum-seeker-did-everything-right-ice-sent-him-to-a-windowless-jail-cell/, Ngo Decl. Ex. F (a former Geauga detainee reported that he "lived in a windowless room from which he could not see the sun or the moon").

guards do not wear protective gloves or masks, even those who appear symptomatic of COVID-19). Detainees are not aware of any additional cleaning measures, and reported receiving little to no information about the pandemic. Burnett Decl. ¶ 16 ("[N]o procedures have changed inside [Seneca over the last six weeks]: no distancing, cleaning, or hygiene measures have been put into place. . . . Detainees have not been provided any information about the disease, its spread, or what might happen to them as a result of it."); DeVito Decl. ¶ 8(d) (observing that Geauga jail staff does not provide detainees with any COVID-19 information or guidance).

Third, Geauga and Seneca have not adequately tested either staff or detainees for COVID-19, enabling its spread. Detainees have experienced symptoms of COVID-19, but not received medical attention or testing. Burnett Decl. ¶ 18 (stating that at least five detainees at Seneca "submitted requests for medical assistance and [] not received any type of medical attention, medication, or testing for COVID-19"); Hoffman Decl. ¶ 7 (observing that no Geauga detainee has been tested for COVID-19 despite exhibiting symptoms resembling COVID-19). Because Geauga and Seneca cannot guarantee widespread testing for COVID-19, the government effectively concedes that Geauga and Seneca staff and detainees will be unaware about who is actually contracting the disease and how far it has spread. Amon Decl. ¶¶ 43–45.

Finally, Geauga and Seneca also cannot ensure adequate treatment of infected detainees. People who contract COVID-19, particularly those with pre-existing conditions, often need intensive medical assistance. Amon Decl. ¶¶ 6–10. Such an advanced level of supportive care requires specialized equipment including ventilators, as well as an entire team of providers, including nurses, respiratory therapists, and physicians, which Geauga and Seneca do not possess.

For these reasons and others enumerated in the supporting declarations, Plaintiffs are at risk of imminent and substantial bodily harm and death.

III. RELEASE FROM DETENTION IS THE ONLY WAY TO PROTECT PLAINTIFFS' SAFETY AND THEIR DUE PROCESS RIGHTS.

In the current, unprecedented circumstances produced by this pandemic, it is impossible for Plaintiffs to remain safe while still detained at Geauga and Seneca. Only their immediate release from detention can vindicate their Due Process rights. Public health experts and prison administrators across the country have made it abundantly clear that medically vulnerable populations kept in detention facilities must be released for their own safety and for the safety of others.[8] Likewise, Ohio Chief Justice Maureen O'Connor has urged "judges to use their discretion and release people held in jail and incarcerated individuals who are in a high-risk category for being infected with the virus."[9] And local authorities in Cuyahoga County declared a state of emergency and expedited the release of over 900 inmates from county jail in March.[10] DHS's own subject matter experts have also stressed that Defendants should release "all detainees in high risk medical groups, such as older people and those with chronic disease." Ngo Decl. Ex. D at 5–6.[11]

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[8] Multiple other jurisdictions have collectively released thousands of people from custody, acknowledging the grave threat posed by a viral outbreak in jails and detention centers. *See* Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020), Ngo Decl. Ex. G at 2 (detailing efforts of jurisdictions around the country to lower jail and prison populations, including Cook County (IL), Autauga County (AL), Allegheny County (PA), Hamilton County (OH), Harris County (TX), and Cuyahoga County (OH)); *see also, e.g.*, Linh Ta, *Iowa's Prisons Will Accelerate Release of Approved Inmates to Mitigate COVID-19*, Times Republican (Mar. 23, 2020), Ngo Decl. Ex. H (announcing Iowa Department of Corrections' plans to expedite release of about 700 inmates to mitigate spread of COVID-19).

[9] *Release Ohio Jail Inmates Vulnerable to Coronavirus, Chief Justice Urges*, WLWT5 (Mar. 19, 2020), https://www.wlwt.com/article/release-ohio-jail-inmates-vulnerable-to-coronavirus-chief-justice-urges/31788560, Ngo Decl. Ex. I.

[10] *See* Adam Ferrise, *Coronavirus Got 900 Inmates Out of Cuyahoga County's Troubled Jail When Inmate Deaths Didn't. Some Say the Changes Should Stick.* (Apr. 1, 2020), https://www.cleveland.com/court-justice/2020/04/coronavirus-got-900-inmates-out-of-cuyahoga-countys-troubled-jail-when-inmate-deaths-didnt-some-say-the-changes-should-stick.html, Ngo Decl. Ex. J.

[11] Former Acting Director of ICE John Sandweg has also publicly called on the agency to release "thousands" of people in order to prevent an outbreak amongst those who work and are detained

The analysis applies with equal force to Geauga and Seneca. *See* Greifinger Decl. ¶ 17 (correctional medical expert recommending release of high-risk individuals as a "key part of a risk mitigation strategy"); Amon Decl. ¶ 56 (infectious disease epidemiologist recommending the same).

ARGUMENT

This Court should grant Plaintiffs a temporary restraining order allowing their release: (1) they are likely to succeed on the merits of their claims; (2) they are likely to suffer irreparable harm in the absence of relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *See Summit Cty. Democratic Ctrl. & Exec. Comm. v. Blackwell*, 388 F.3d 547, 552 (6th Cir. 2004). The Court may order immediate release under either 28 U.S.C. § 2241, or 28 U.S.C. § 1331.

IV. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

Plaintiffs are likely to establish that Defendants violated—and continue to violate—Plaintiffs' constitutional rights by condemning them, notwithstanding their particular medical vulnerabilities, to confined, close quarters, where it is impossible to practice social distancing. Defendants *cannot* adequately remedy any potential harm suffered by Plaintiffs as a result of COVID-19. Accordingly, Plaintiffs' continued detention at Geauga and Seneca violates their Fifth Amendment rights.

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in ICE's facilities. *See* John Sandweg, *I Used to Run ICE. We Need to Release the Nonviolent Detainees*, The Atlantic (Mar. 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536/, Ngo Decl. Ex. K.

A. Plaintiffs' Continued Detention at Geauga and Seneca Violates the Fifth Amendment.

Defendants have violated, and continue to violate, Plaintiffs' constitutional Due Process rights by detaining them in conditions that in no way "reasonably relate[] to a legitimate governmental purpose." *Bell v. Wolfish,* 441 U.S. 520, 539 (1979). As civil detainees, Plaintiffs' detention is governed by the Fifth Amendment. *Id*. Under the Fifth Amendment, civil detention may not "amount to punishment of the detainee." *Id.* at 535. Because of their underlying health conditions, which make them especially vulnerable to infection from COVID-19, the condition of Plaintiffs' confinement is not "reasonably related to a legitimate governmental objective"; instead it is "arbitrary or purposeless[.]" *Id.* at 539; *see also J.H. v. Williamson Cty., Tenn.*, 951 F.3d 709, 717 (6th Cir. 2020) (applying *Bell* test to pre-trial detainee's conditions of confinement claim).[12]

[12] Although Plaintiffs' claims are governed by the Fifth Amendment, their continued detention would also violate the Eight Amendment's much more stringent "deliberate indifference" standard. The Supreme Court has recognized that the government is deliberately indifferent, and therefore violates the Eighth Amendment, when it "ignores a condition of confinement that is sure or very likely to cause serious illness" by crowding Plaintiffs into living quarters with others who have "infectious maladies . . . even though the possible infection might not affect all of those exposed." *Helling v. McKinney*, 509 U.S. 25, 32–33 (1993). Here, as explained in detail above, the overwhelming evidence shows that COVID-19 poses a serious risk to Plaintiffs, and that continued detention would amount to deliberate indifference under the circumstances. *See Bell*, 441 U.S. at 539. *Malam*, 2020 WL 1672662 at *12; *Thakker v. Doll*, 2020 WL 1671563, at *8 n.15 (M.D. Pa. Mar. 31, 2020). Moreover, the Supreme Court has clarified that the Eighth Amendment's deliberate indifference standard does not apply to pre-trial detainees. In *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2473 (2015), the Court held that a pretrial detainee's Fourteenth Amendment excessive force claim need only meet the objective component of a deliberate indifference claim by showing that "the force purposely or knowingly used against him was objectively unreasonable." *Id*. As the Sixth Circuit has recognized, "this shift in Fourteenth Amendment deliberate indifference jurisprudence calls into serious doubt whether [a detainee] need even show that the individual defendant-officials were subjectively aware of [the detainee's] serious medical conditions and nonetheless wantonly disregarded them." *Richmond v. Huq*, 885 F.3d 928, 938 n.3 (6th Cir. 2018). *See also Griffith v. Franklin Cty., Ky.*, 2019 WL 1387691, at * 5 (E.D. Ky. 2019) (holding that after *Kingsley*, a pretrial detainee need not show subjective deliberate indifference). While Plaintiffs here satisfy either standard, there is no need for the Court to reach these issues. It can simply apply *Bell*, as recently reaffirmed by the Sixth Circuit in *J.H. v. Williamson Cty., Tenn.*, 951 F.3d 709 (6th Cir. 2020).

Plaintiffs' detention is not "reasonably related" to its objective because it creates a serious risk of imminent illness and death. *See Bell*, 441 U.S. at 539. In all likelihood, there are detainees or staff at both Geauga and Seneca carrying COVID-19 asymptomatically, making it only a matter of time before they begin to show symptoms. *See supra* Facts II-III. This risk is urgent, imminent, and unrelated to any legitimate governmental goal, as several federal courts have already held. *See, e.g.*, *Malam v. Adducci*, __ F. Supp. 3d __, 2020 WL 1672662 (E.D. Mich. Apr. 5, 2020) (holding that immigrant petitioner's continued detention in Michigan is both unrelated and contrary to the government purpose of carrying out her removal proceedings); *Xochihua-Jaimes v. Barr*, __ F. App'x __, No. 18-71460, 2020 WL 1429877 (9th Cir. Mar. 24, 2020) (*sua sponte* ordering immediate release of immigrant petitioner "[i]n light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers"); *Thakker v. Doll*, __ F. Supp. 3d __, 2020 WL 1671563, at *8 (M.D. Pa. Mar. 31, 2020) ("We can see no rational relationship between a legitimate government objective and keeping Petitioners detained in unsanitary, tightly-packed environments.").

B. Plaintiffs' Release Is the Sole Effective Remedy for the Constitutional Violation at Issue.

Plaintiffs' immediate release is the sole effective remedy for the constitutional violation here. When the government fails to meet its obligations to provide adequate care, courts have a responsibility to remedy the constitutional violation using their broad powers to fashion equitable relief. *See Brown v. Plata*, 563 U.S. 493, 511 (2011) ("When necessary to ensure compliance with a constitutional mandate, courts may . . . plac[e] limits on a prison's population.").

To vindicate detainees' Due Process rights in the face of the COVID-19 pandemic, federal and state courts across the country have ordered the release of detained individuals. *See, e.g.*, *L.O. v. Tsoukaris*, No. 20-3481 (JMV) (D.N.J. Apr. 9, 2020); *Bent v. Barr*, No. 19-cv-06123-DMR

(N.D. Cal. Apr. 9, 2020); *Bahena Ortuno v. Jennings*, No. 20-cv-020640-MMC (N.D. Cal. Apr. 8, 2020); *Malam*, 2020 WL 1672662; *Coronel v. Decker*, No. 20-cv-2472, 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020); *Calderon Jimenez v. Wolf*, No. 18-10225-MLW, ECF No. 507 (D. Mass. Mar. 26, 2020).[13] On March 23, 2020, the Ninth Circuit ordered, *sua sponte*, the release of an immigrant petitioner "[i]n light of the rapidly escalating public health crisis, which . . . authorities predict will especially impact immigration detention centers." *Xochihua-Jaimes*, 2020 WL 1429877, at *1.

In this case, as in the many similar cases listed above, the Plaintiffs' immediate release from detention is the only effective remedy for the constitutional violation they are suffering. There is no known cure or treatment for COVID-19, no known vaccine, and no known natural immunity. Social distancing is essential to mitigate the spread of contagion. *See supra* Facts II. At Geauga and Seneca, Plaintiffs cannot maintain the necessary distance from either their fellow detainees or the staff at the facility sufficient to protect their health.

Because Plaintiffs have shown that their continued detention would cause an unacceptably high risk of grave injury, Plaintiffs are likely to succeed on the merits of their claim that their continued detention violates their rights under the Fifth Amendment, and that release from custody is the only permissible way to ensure their safety and the safety of others with whom they are currently in close and daily contact.

[13] *See also Umana Jovel v. Decker et al.*, 20 Civ. 308, 2020 WL 1467397, at *2 (S.D.N.Y. Mar. 26, 2020) (granting emergency request for release of petitioner from immigration detention in light of the COVID-19 crisis); *United States v. Martin*, No. 19-cr-140-13, 2020 WL 1274857, at *2 (D. Md. Mar. 17, 2020) (explaining that exposure to COVID-19 can lead to "serious (potentially fatal, if the detainee is elderly and with underlying medical complications) illness"); Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff (Mar. 16, 2020), Ngo Decl. Ex. L (ordering, with exceptions, everyone held on bond in a non-capital case be released).

V. THE OTHER FACTORS REQUIRED FOR A TEMPORARY RESTRAINING ORDER TIP SHARPLY IN FAVOR OF RELEASING PLAINTIFFS.

A. Plaintiffs' Exposure to COVID-19 Constitutes Irreparable Harm.

Plaintiffs, because of their underlying medical conditions, which make them especially susceptible to severe infection from COVID-19, confront immediate danger in violation of their Due Process rights. "When constitutional rights are threatened or impaired, irreparable injury is presumed." *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012). Further, Plaintiffs' continued detention will inevitably delay or prevent them from obtaining medical services, which threatens to worsen Plaintiffs' health and exacerbate the risk they face. *See Wilson v. Gordon*, 822 F.3d 934, 958 (6th Cir. 2016) ("Courts routinely uphold preliminary injunctions where the alleged irreparable harm involves delay in or inability to obtain medical services.").

B. The Public Interest and the Balance of Equities Weigh Heavily in Plaintiffs' Favor.

So long as they continue to be confined at Geauga and Seneca, Plaintiffs' lives are in danger in violation of their Due Process rights. Releasing them from detention with the proper public health and safety precautions will protect their safety and remedy the continued violation of their constitutional rights, which is in the public interest. *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 222 (6th Cir. 2016) (holding that protection of constitutional rights is "a purpose that is always in the public interest"). Plaintiffs' release, subject to public health and safety precautions like GPS monitoring and home confinement, will also promote Defendants' interest in ensuring the safety of the other detainees, facility staff, and community at large. Greifinger Decl. ¶¶ 17–19.

An occurrence of disease at Geauga or Seneca would soon become a "tinderbox scenario" with dire consequences for detainees and workers as well as the Geauga and Seneca County areas, which would be drained of its limited medical resources, including intensive care unit beds and ventilators. In Ohio, the COVID-19 outbreak has already resulted in unprecedented public health

measures and has strained the local health care system. Amon Decl. ¶ 33. Releasing vulnerable individuals will reduce the burden on the local community and health infrastructure and is clearly in the public interest. Amon Decl. ¶¶ 33, 56. *See Calderon Jimenez*, No. 18-10225-MLW at 4.[14]

VI. PLAINTIFFS MAY SEEK RELIEF THROUGH BOTH HABEAS AND AN IMPLIED CAUSE OF ACTION UNDER THE DUE PROCESS CLAUSE.

Plaintiffs may seek relief both under 28 U.S.C. § 2241, as a habeas corpus petition, and 28 U.S.C. § 1331, as an independent cause of action for injunctive relief under the Due Process Clause. Both are appropriate vehicles; this Court may order immediate release under either.

28 U.S.C. § 2241(d) provides habeas jurisdiction over an individual held "in custody in violation of the Constitution or laws or treaties of the United States." Claims for "immediate discharge from . . . confinement" fall within the "core of habeas corpus," *Prieser v. Rodriguez*, 411 U.S. 475, 487 (1973), and Plaintiffs seek immediate release. *See* Pet. ¶ 8. Indeed, the claim brought by Plaintiffs—a due process challenge to the fact of their civil immigration detention—is regularly reviewed in habeas proceedings. *See, e.g.*, *Zadvydas v. Davis*, 533 U.S. 678, 684–85, 690 (2001) (due process challenge to detention brought in habeas). Accordingly, numerous federal courts across the circuits have found habeas jurisdiction proper to order release to remedy the same injury faced by Plaintiffs here.[15] Given Plaintiffs' vulnerabilities, and the manner in which COVID-19 spreads in congregate settings like Geauga and Seneca, there are *no* detention

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[14] As detained, indigent individuals, Plaintiffs request this Court to exercise its discretion to require no security in issuing this relief. *Urbain v. Knapp Bros. Mfg. Co.*, 217 F.2d 810, 815–16 (6th Cir. 1954) ("[T]he matter of requiring security in each case rests in the discretion of the District Judge.").

[15] *See, e.g.*, *Coronel v. Decker*, No. 20-cv-2472 (AJN),——F. Supp. 3d.——, 2020 WL 1487274, at *1 (S.D.N.Y. Mar. 27, 2020); *Bravo Castillo v. Barr*, No. 20-cv-00605 TJH (AJMx), ——F. Supp. 3d——, 2020 WL 1502864, at *6 (C.D. Cal. Mar. 27, 2020); *Thakker v. Doll*, No. 1:20-cv-480, ECF No. 47, at 22, 25 (M.D. Pa. Mar. 31, 2020); *see also Coreas v. Bounds*, No TDC-20-0780, ECF No. 56, at 14–15 (D. Md. Apr. 3, 2020) (agreeing that "a claim by an immigration detainee seeking release . . . is cognizable under § 2241").

conditions that can adequately or constitutionally house them, and release is the necessary relief. *See Malam*, 2020 WL 1672662 at *4 (finding habeas jurisdiction appropriate where immigrant detainee petitioner argued "that no matter what steps [were] taken [to mitigate the risk of infection], due to her underlying serious health conditions, there [was] no communal holding facility where she could be incarcerated during the Covid-19 pandemic that would be constitutional"); *see also Lopez-Marroquin v. Barr*, No. 18-72922 (9th Cir. Apr. 9, 2020) ("[D]istrict courts retain jurisdiction under 28 U.S.C. § 2241 to consider habeas challenges to immigration detention that are sufficiently independent of the merits of the removal order[.]").

Plaintiffs also have an independent cause of action in equity under the Fifth Amendment. Federal courts have long recognized an implicit private right of action under the Constitution "as a general matter" to issue prospective injunctive relief against government action. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 491 n.2 (2010); *Bolling v. Sharpe*, 347 U.S. 497 (1954). Thus, this Court has jurisdiction under 28 U.S.C. § 1331 to enjoin the Defendants' unconstitutional actions. *See Malam*, 2020 WL 1672662, at *4 ("Should Petitioner's habeas petition fail on jurisdictional grounds, the Fifth Amendment provides Petitioner with an implied cause of action, and accordingly 28 U.S.C. 1331 would vest the Court with jurisdiction."). *See also* Pet. ¶ 8.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for a temporary restraining order and direct Plaintiffs' immediate release from Geauga and Seneca.

Dated: April 10, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 10, 2020, a copy of the foregoing pleading was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties have acess to this filing through the Court's system. I further certify that a copy of the foregoing pleading and Notice of Electronic filing has been served by ordinary U.S. mail upon all parties for whom counsel has not yet entered an appearance.

/s/ Freda J. Levenson
Freda J. Levenson

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

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

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

COVID-19

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of April 8, 2020, according to the World Health Organization, 1,353,361 have been diagnosed with COVID-19 around the world and 79,235 people have died; in the United States, about 363,321 people have been diagnosed and 10,845 people have died thus far.[2] These numbers are likely an underestimate, due to the lack of availability of testing, in countries like the United States.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti- viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

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

[2] World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-79, Apr. 8, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200408-sitrep-79-covid-19.pdf?sfvrsn=4796b143_6.

5. People in the high-risk category for COVID-19, i.e., elderly adults or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are definitely in very short supply.

7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy.

The Risks of COVID-19 in Immigration Detention

9. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

10. Immigration detention facilities are enclosed environments, much like the cruise ships and nursing homes that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

11. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

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

12. In addition to these challenges, ICE has failed to adequately respond to the COVID-19 pandemic. I have reviewed the March 6, 2020 interim guidance sheet[3] produced by ICE Health Services Corps, the body that oversees ICE detention facilities' medical care, ICE's guidance on its website,[4] as well as a subsequent Revised COVID-19 Action Plan memorandum from ICE dated March 27, 2020. These protocols are wholly insufficient to adequately face the crisis at hand. They fail in these ways:

    a) ICE's protocol focuses on travel history and contact with confirmed cases of COVID-19. This misses the mark. At this point in the course of the virus, nearly everyone who is not practicing social distancing is in contact with someone who has the virus.

    b) While the protocol provides for testing for symptomatic detainees, there is no guidance on cohorting and monitoring contacts of test-positive detainees for a 14-day period.

    c) Moreover, there is no protocol for testing of asymptomatic detainees or staff and other individuals, like vendors and attorneys, who enter the detention facility.

    d) Staff is an especially important vector in this outbreak. Since they go back and forth between the outside world, detention centers will be hit by COVID-19 when the rest of the community is, staff and their families included.

    e) The ICE protocol does not follow the measures in the CDC guidelines for long term care facilities. Specifically, it does not ensure access to hand sanitizer nor does it provide masks for detainees with a cough.

    f) The ICE protocol does not provide guidance on how to deal with surge capacity, which will almost certainly be necessary as the number of cases in the detention facility increase and the number of healthy staff to treat detained people decreases.

    g) ICE purports to be evaluating its detained population for higher-risk individuals. Aside from the unclear medical criteria ICE is using, it has also only identified a fraction of that group to be eligible for release. Moreover, there is no guidance in the protocol to identify high-risk patients or steps to protect them from contracting COVID-19. The plan needs to include an improved intake process, cohorted housing areas for high risk patients, increased infection control measures, and increased medical surveillance, including daily checks for signs and symptoms.

    h) Although detainees are instructed on the importance of social distancing, there is no guarantee that social distancing of six feet, as recommended by the CDC, will

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

[4] U.S. Immigration and Customs Enforcement, *ICE Guidance on COVID-19*, ICE.GOV (last updated Apr. 9, 2020), https://www.ice.gov/covid19.

be carried out in all ICE facilities. In fact, social distancing is likely impossible in such facilities, especially in light of the common practice of facility lockdowns.

i) There are no clear criteria for hospital transfer. As clinical staff have no experience with this disease, ICE should develop rational clinical criteria for transfer to an acute care hospital.

13. The ICE response envisions using isolation rooms to monitor individuals with COVID-19 symptoms. However, many facilities only have 1-4 of these rooms available in the facility. There will be many more than 1-4 people with COVID-19 in the detention center. Instead, ICE must create entire housing units reserved for people with COVID-19 symptoms, so that symptomatic patients can live separately from those who are asymptomatic or at risk. Because of how full ICE facilities are, this will be nearly impossible.

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

15. Transferring individuals between facilities, a common ICE practice, is medically inappropriate during the outbreak. ICE does not have the staffing needed to monitor the transferred patients for the appropriate 14-day period to check for symptoms.

16. ICE must release all people with risk factors to prevent serious illness including death. ICE's response has made abundantly clear that they do not plan to establish special protections for high-risk patients, instead waiting for them to become symptomatic. This will lead to unnecessary illness and death for the people most vulnerable to this disease. ICE is walking willingly into a preventable disaster by keeping high-risk and vulnerable patients in detention facilities during the rapid spread of COVID-19.

17. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. Release also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

18. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.

19. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from detention by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with local or state public health authorities.

Plaintiffs are at Risk for Serious Illness and Death from COVID-19

20. I have reviewed the factual claims of Plaintiffs' medical conditions made in Plaintiffs' complaint. On the basis of the claims presented, I conclude that Plaintiffs in this lawsuit present with personal health characteristics that put them at high risk for complications from COVID-19 should they be exposed to the virus in detention.

    a) Upon information and belief, Romel Amaya-Cruz has advanced HIV disease (AIDS). As a result, he is at higher risk for complications from COVID-19 due to these medical conditions.

    b) Upon information and belief, Jonas Nsogni Mbonga has chronic amebiasis, a debilitating infection of the intestines. As a result, he is at higher risk for complications from COVID-19 due to these medical conditions.

    c) Upon information and belief, Elvira Pascalenco has chronic asthma and other chronic conditions. As a result, she is at higher risk for complications from COVID-19 due to these medical conditions.

    d) Upon information and belief, Hector Manuel Reyes-Cruz has hypertension. As a result, s/he is at higher risk for complications from COVID-19 due to these medical conditions.

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

Executed this *9th* day in April 2020 in New York City, New York.

Robert B. Greifinger, M.D.

ROBERT B. GREIFINGER, M.D.

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

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

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

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

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

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

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

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

ROBERT B. GREIFINGER, M.D.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1985 - 1989

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

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

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

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

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

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

Vice President and Medical Director

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

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

COMMUNITY HEALTH PLAN OF SUFFOLK, INC. 1977 - 1980

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

Medical Director

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

MONTEFIORE MEDICAL CENTER, Bronx, NY 1976 - 1977

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

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

UNITED STATES PUBLIC HEALTH SERVICE 1972 - 1974

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

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

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

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

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

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

OTHER PROFESSIONAL ACTIVITIES

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

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

EDUCATION

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

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

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

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

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

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Updated February 2018

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ABSTRACTS & RESEARCH PRESENTATIONS

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Declaration of Joseph J. Amon, Ph.D. MSPH

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master's of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.

2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.

3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.

4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of today (April 10, 2020), according to the World Health Organization, 1,479,168 people have been diagnosed with COVID-19 in 212 countries or territories around the world and 87,987 have died.[1] In the United States, about 466,299 people have been diagnosed with the disease and 16,686 people have died thus far.[2] Ohio has 5,512

[1] *See Coronavirus Disease (COVID-19) Pandemic*, WORLD HEALTH ORG., https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last viewed April 10, 2020).
[2] *See Coronavirus COVID-19 Global Cases*, JOHNS HOPKINS UNIV., https://coronavirus.jhu.edu/map.html (last viewed April 10, 2020).

confirmed cases including 213 deaths from COVID-19.[3] These numbers are likely an underestimate, due to the lack of availability of testing. In many settings, the numbers of infected people are growing at an exponential rate.

6. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death. Those with serious cases of COVID-19 will likely require advanced support, including positive pressure ventilation and extracorporeal mechanical oxygenation in an intensive care setting. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections. Those who survive serious cases of COVID-19 may require long-term rehabilitation because of damage to lung tissue and possibly other organs, including the heart, kidney, and neurologic systems.

7. The World Health Organization (WHO) identifies individuals at highest risk to include older people and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.[4] The WHO further states that the risk of severe disease increases with age starting from around 40 years.[5]

8. The US CDC identifies "older adults [65 and older] and people of any age who have serious underlying medical conditions" as at higher risk of severe disease and death.[6] The CDC identifies underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.[7]

9. Data from US COVID-19 cases published by the CDC on March 19, 2020, found that hospitalization rates and intensive care unit (ICU) admission rates were nearly identical for individuals aged 45-54 and individuals aged 55-64 (between approximately 20-30% for both groups for hospitalization and between 5-11% for both groups for ICU admission).[8] This suggests that individuals >45 years could be

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[3] *Coronavirus (COVID-19)*, OHIO DEP'T OF HEALTH (last updated Apr. 9, 2020), https://coronavirus.ohio.gov/wps/portal/gov/covid-19/home.

[4] *See Coronavirus disease 2019 (COVID-19) Situation Report – 79*, WORLD HEALTH ORG., https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200408-sitrep-79-covid-19.pdf?sfvrsn=4796b143_6 (last updated Apr. 8, 2020).

[5] *Id.*

[6] *See Groups at Higher Risk for Severe Illness*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 2, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html.

[7] *See Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 12, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf.

[8] *See Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 26, 2020),

considered high risk for severe disease while those ≥54 years could be considered high risk for severe disease and death.

10. Public Health England, the public health authority of the United Kingdom, identifies a broader list of individuals at increased risk of severe illness and who should be "particularly stringent in following social distancing measures".[9] These include: individuals with: chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis; chronic heart disease, such as heart failure; chronic kidney disease; chronic liver disease, such as hepatitis; chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy; diabetes; spleen-related disorders or having had your spleen removed; having a weakened immune system; having a body mass index (BMI) of 40 or above; and those who are pregnant.

Understanding of COVID-19 Transmission

11. According to the U.S. CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.[10] 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 possibly their eyes, but this is not thought to be the main way the virus spreads.[11] People are thought to be most contagious when they are most symptomatic (the sickest), however some amount of asymptomatic transmission is likely.[12] **This suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.**

12. People are thought to be most contagious when they are most symptomatic (the sickest), however there is increasing evidence of asymptomatic[13] and presymptomatic transmission. A recent report by the CDC his of presymptomatic transmission in

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https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm.

[9] *See Guidance on Social Distancing for Everyone in the UK*, PUBLIC HEALTH ENGLAND (updated Mar. 30, 2020), https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults.

[10] *How to Protect Yourself & Others*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html (last updated Apr. 2, 2020).

[11] *How COVID-19 Spreads*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html (last updated Apr. 2, 2020).

[12] *See id.*; *see also* Yan Bai et al., *Presumed Asymptomatic Carrier Transmission of COVID-19*, JAMA (Feb. 21, 2020), doi:10.1001/jama.2020.2565; Wei Zhang et al., *Molecular and Serological Investigation of 2019-nCoV Infected Patients: Implication of Multiple Shedding Routes*, 9 EMERGING MICROBES & INFECTIONS 386 (2020).

[13] *See* https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020; See also: Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19.JAMA. Published online February 21, 2020. doi:10.1001/jama.2020.2565 and Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020;9(1):386-389.

Singapore identified seven clusters of COVID-19 in which presymptomatic transmission likely occurred, accounting for 6.4% of locally acquired cases examined.[14] These findings are similar to research outside of Hubei province, China, which found that 12.6% of transmissions could have occurred before symptom onset in the source patient.[15] Speech and other vocal activities such as singing have been shown to generate air particles which could transmit the virus responsible for COVID-19, with the rate of emission corresponding to voice loudness. News outlets have reported that during a choir practice in Washington on March 10, presymptomatic transmission likely played a role in SARS-CoV-2 transmission to approximately 40 of 60 choir members.[16]

13. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. All 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.[17] Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. For instance, Governor Mike DeWine has issued an executive order declaring a state of emergency,[18] pursuant to which the Director of the Ohio Department of Health has shut down schools and non-essential businesses and urged people to stay home and avoid in-person contact with individuals outside of their household.[19]

14. As of April 1, in response to the threat of COVID-19 transmission, sixteen states prohibit gatherings of any size (Alaska, California; Colorado; Idaho Illinois; Indiana; Montana; Michigan; New Jersey; New Mexico; New York; Ohio; Oregon; Washington; West Virginia; and Wisconsin); two states prohibits gatherings > 5 individuals (Connecticut and Rhode Island); twenty-two states and the District of Columbia prohibit gatherings of >10 individuals (Alabama; Arizona; Arkansas; Hawaii; Iowa; Kansas; Louisiana; Maine; Maryland; Massachusetts; Mississippi; Missouri; Nevada; New Hampshire; North Carolina; Oklahoma; South Dakota; Tennessee; Texas; Vermont; Virginia; and Wyoming); and two states prohibit gatherings of >50 individuals (Delaware; South Carolina). The majority of states have also issued quarantine orders directing residents to stay at home except under certain

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[14] *See* Wycliffe Wei et al., *Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e1.htm?s_cid=mm6914e1_w (last visited April 2, 2020).

[15] *See* Zhanwei Du et al., *Serial Interval of COVID-19 among Publicly Reported Confirmed Cases*, 26 EMERGING INFECTIOUS DISEASES (2020), https://wwwnc.cdc.gov/eid/article/26/6/20-0357_article.

[16] *See* Richard Read, *A Choir Decided to Go Ahead With Rehearsal. Now Dozens Of Members Have COVID-19 and Two are Dead*, LA TIMES, https://www.latimes.com/world-nation/story/2020-03-29/coronavirus-choir-outbreak last visited April 2, 2020.

[17] *Coronavirus Disease 2019 (COVID-19) Response Hub*, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, https://coronavirus-astho.hub.arcgis.com (last visited Mar. 21, 2020).

[18] Mike DeWine, *Executive Order 2020-01D*, GOVERNOR STATE OF OHIO (Mar. 14, 2020), *available at*

[19] Amy Acton, MD, MPH, *Amended Director's Stay At Home Order*, OHIO DEPARTMENT OF HEALTH (Apr. 2, 2020), https://coronavirus.ohio.gov/static/publicorders/Directors-Stay-At-Home-Order-Amended-04-02-20.pdf.

narrow exceptions.[20] These orders are expanding, increasing. Whereas at least 158 million people in 16 states, nine counties and three cities were being urged to stay home on March 23, the numbers increased on March 24, 2020 to at least 163 million people in 17 states, 14 counties and eight cities. On March 27, at least 228 million people in 25 states, 74 counties and 14 cities and one territory were being urged to stay home. And by April 7, that number had increased to 316 million people in 42 states, 3 counties, 9 cities, the District of Columbia and Puerto Rico.[21]

15. These public health measures aim to "flatten the curve" of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.

16. In countries where the virus's course of infection began earlier, and where death rates grew steadily, governments have imposed national emergency measures to prevent contagion from human contact. In Italy and Spain, for example, the governments have imposed national lockdowns to keep people from coming into contact with each other.[22]

17. In Spain, immigration authorities began gradually releasing people held in closed immigration detention centers (CIEs) on March 18.[23] In Belgium, federal authorities released an estimated 300 migrants from detention on March 19 because detention conditions did not allow for safe social distancing.[24] The UK government released 300 people from detention centers following legal action that argued that the government had failed to protect immigration detainees from the COVID-19 outbreak and failed to identify which detainees were at particular risk of serious harm or death if they do contract the virus due to their age or underlying health conditions. As part of the legal action, Professor Richard Coker of the London School of Hygiene and Tropical Medicine stated that prisons and detention centers provide "ideal incubation conditions for the rapid spread of the coronavirus, and that about 60% of those in detention could be rapidly infected if the virus gets into detention centers."[25]

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[20] *State Data and Policy Actions to Address Coronavirus*, KAISER FAMILY FOUNDATION (Apr. 2, 2020), https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus.

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

[22] *Spain Impose Nationwide Lockdown Due to Virus, Closes All Stores Except Groceries and Pharmacies*, CNBC (Mar. 14, 2020, 4:06 PM), https://www.cnbc.com/2020/03/14/spain-declares-state-of-emergency-due-to-coronavirus.html.

[23] Europa Press, Madrid, *Interior abre la puerta a liberar a internos en los CIE por el coronavirus*, LA VANGUARDIA (Mar. 19, 2020, 7:54 PM), https://www.lavanguardia.com/politica/20200319/474263064358/interior-abre-puerta-liberar-internos-cie.html.

[24] *300 mensen zonder papieren vrijgelaten: coronavirus zet DVZ onder druk*, DE MORGAN, https://www.demorgen.be/nieuws/300-mensen-zonder-papieren-vrijgelaten-coronavirus-zet-dvz-onder-druk~bf3d626d/ (last visited Mar. 23, 2020).

[25] Diane Taylor, *Home Office Releases 300 from Detention Centres amid Covid-19 Pandemic*, THE GUARDIAN (Mar. 21, 2020, 3:08 PM), https://www.theguardian.com/uk-news/2020/mar/21/home-office-releases-300-from-detention-centres-amid-covid-19-pandemic.

18. US cities are starting to see the level of COVID-19 cases seen in previous global hotspots. On Thursday, March 26, Governor Cuomo announced that in New York, 100 people had died of the coronavirus between Wednesday and Thursday morning.[26] As of two weeks later, Thursday April 9, the cumulative death toll in the state stood at 6,268.[27]

Risk of COVID-19 in Immigration Detention Facilities

19. The conditions in immigration detention facilities do not allow detained individuals or staff to protect themselves and therefore are likely to facilitate the spread of COVID-19.

20. Immigration detention facilities are often overcrowded environments, in which individuals, including those with high risk of serious illness or death if they contract COVID-19 cannot practice social distancing or readily access adequate medical care. . People sleep and eat in close quarters, and use toilets, showers, and sinks together without proper disinfectant or sanitizing measures.

21. Staff members regularly enter and leave the facility without proper screening for asymptomatic or presymptomatic infection, and detainees have no way to socially distance themselves from staff members.

22. As COVID-19 enters into immigration detention facilities, these facilities will likely be unable to address the infectious spread and the needs of infected individuals due to lack of testing and insufficient physical and medical infrastructure.

23. In cases where there are confirmed or suspected cases of COVID-19 in immigration detention centers, the CDC recommends medical isolation, defined by the CDC confining the case "ideally to a single cell with solid walls and a solid door that closes" to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space.[28]

24. Individuals in close contact of a confirmed or suspected COVID-19 case—defined by the CDC as having been within approximately 6 feet of the individual for a prolonged period of time or having had direct contact with secretions of a COVID-19 case (e.g., have been coughed on)—should be quarantined for a period of 14 days. The same precautions should be taken for housing someone in quarantine as for someone who is a confirmed or suspected COVID-19 case put in isolation.[29]

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[26] *U.S. Now Leads the World in Confirmed Cases*, N.Y. TIMES, https://www.nytimes.com/2020/03/26/world/coronavirus-news.html (last updated Apr. 7, 2020).
[27] *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited Apr. 9, 2020).
[28] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTER FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last updated Mar. 23, 2020).
[29] *Id.*

25. The CDC guidance recognizes that housing detainees in isolation and quarantine individually, while "preferred", may not be feasible in all immigration detention settings and discusses the practice of "cohorting" when individual space is limited. The term "cohorting" refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a particular case together as a group. The guidance states specifically that "Cohorting should only be practiced if there are no other available options" and exhorts correctional officials: "**Do not cohort confirmed cases with suspected cases or case contacts."**[30] Individuals who are close contacts of different cases should also not be kept together.

26. The CDC guidance also says that detention facilities should "Ensure that cohorted cases wear face masks at all times."[31] This is critical because not all close contacts may be infected and those not infected must be protected from those who are if individuals are cohorted. However, it is important to note that face masks are in short supply. In a joint letter to President Trump, the American Medical Association, the American Hospital Association, and the American Nurses Association called on the administration to "immediately use the Defense Production Act to increase the domestic production of medical supplies and equipment that hospitals, health systems, physicians, nurses and all front line providers so desperately need."[32] In a survey United States cities, 91.5% of the cities reported that they do not have an adequate supply of face masks for their first responders and medical personnel.[33] There are also widespread shortages of personal protective equipment — particularly N-95 masks — sufficient to provide even for health care workers, in our nation's hospitals, let alone medical providers and other individuals coming into contact with the virus in immigration detention facilities.[34] Many public health leaders are calling for masks to be reserved for health care staff, who face increased risk and are vitally needed to sustain emergency care. Hospitals in the New York City area, unable to access masks locally, are reportedly turning to a private distributor to airlift millions of protective masks out of China.[35] Face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it;

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[30] *Id.* (emphasis in original).
[31] *Id.*
[32] *AHA, AMA and ANA Letter to the President to Use DPA for Medical Supplies and Equipment*, AM. HOSP. ASS'N (Mar. 21, 2020), https://www.aha.org/lettercomment/2020-03-21-aha-ama-and-ana-letter-president-use-dpa-medical-supplies-and-equipment.
[33] *Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation's Mayors*, THE UNITED STATES CONFERENCE OF MAYORS, https://www.usmayors.org/issues/covid-19/equipment-survey/ (last visited Mar. 28, 2020).
[34] Michael T. Osterholm & Mark Olshaker, Opinion, *It's Too Late to Avoid Disaster, but There Are Still Things We Can Do*, N.Y. TIMES (Mar. 27, 2020), https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html.
[35] Christina Jewett & Lauren Weber, *Hospital Suppliers Take to the Skies to Combat Dire Shortages of COVID-19 Gear*, LANCASTER ONLINE (Mar. 26, 2020), https://lancasteronline.com/news/health/hospital-suppliers-take-to-the-skies-to-combat-dire-shortages/article_0830ffb0-6f89-11ea-89ed-bbd859186614.html.

and replacing the mask with a new one if it becomes damp (e.g., from sneezing) and not to re-use single-use masks. There are times when detainees will necessarily not be able to wear masks, if available—for example, during meals. In these instances, detainees should eat individually or with proper distancing from others.

27. Where individual rooms are not available, the CDC guidance describes a hierarchy of next best options for cohorting, which in order from lesser risk to greater risk includes housing individuals under medical isolation: 1) in a large, well-ventilated cell with solid walls and a solid door that closes fully; 2) in a large, well-ventilated cell with solid walls but without a solid door; 3) in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells; 4) in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells.[36]

28. When a single COVID-19 case is identified in an immigration detention facility, close contact and the inability of detention facilities to implement social distancing policies due to overcrowding and the physical limitations of the facility, as described above, means that there will be many individuals who are exposed and will need to be quarantined.

29. CDC guidance for detention facilities specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons "ideally 6 feet between all individuals, regardless of the presence of symptoms" including: 1) increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.[37]

30. The CDC guidance also describes necessary disinfection procedures including to thoroughly clean and disinfect all areas where a confirmed or suspected COVID-19 case spent time.[38]

31. Detention facilities were not built to implement the CDC guidance, or for the needs of this kind of pandemic. If COVID is introduced there will likely be many more individuals identified as "close contacts" who need to be quarantined than there are safe spaces to isolate them. Some individuals identified as "close contacts" will likely be infected while others will not. "Cohorting" of all contacts together is likely to

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[36] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTER FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last updated Mar. 23, 2020).
[37] *Id.*
[38] *Id.*

facilitate rather than prevent disease transmission. This is particularly true without strict attention to masking and proper hygiene and sanitation distancing.

32. If officers and medical personnel are significantly affected by COVID-19, large numbers will also be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

33. Large numbers of ill detainees and staff will also strain the limited medical infrastructure in the counties in which these detention facilities are located. If infection spreads throughout the detention center, overwhelming the center's own limited resources, the burden of caring for these individuals will shift to local medical facilities. The few facilities will likely not be able to provide care to all infected individuals with serious cases. Ohio health care providers worry that the state does not have sufficient ventilators or medical supplies to care for patients sick with COVID-19.[39] If the virus spreads through immigration detention facilities, it is likely that many individuals will need to be transferred (while in isolation) to community hospitals, and this system will be even more taxed. The inability for overwhelmed community hospitals to provide necessary care will increase the likelihood that individuals with COVID-19 will not be able to get proper care and die.[40]

Risk of COVID-19 Transmission at the Geauga and Seneca Detention Facilities

34. I have reviewed the declarations of the attorneys for Plaintiffs Romel Amaya-Cruz, Jonas Mbunga, Elvira Pascalenco, and Hector Manuel Reyes Cruz. Based on their declarations, neither the Geauga nor Seneca facilities appear to be adopting the procedures necessary to prevent COVID-19 transmission.

35. The declarations indicate that at Geauga, pods may house up to 60 people in a single room dormitory, with bunks only a few feet apart. Detainees are currently being held with 20 or 30 other individuals in the same dormitory. Even in the women's pods, detainees often share cells in which the beds are very near each other. At Seneca, 35 detainees are sharing the jail's 40-bed dormitory-style housing unit, where beds are about 3 feet apart. Individuals at both facilities are therefore not able to practice social distancing in their housing areas because they cannot stay 6 feet apart from one another.

36. The declarations describe how detainees generally eat together, sharing communal tables that are not sanitized between use. For recreation, they also gather in the same

[39] Darrel Rowland et al., *Coronavirus: Amid Scarce Resources, Ohio Not Ready to Decide Who Gets Treated First*, THE COLUMBUS DISPATCH (Apr. 5, 2020, 1:58 PM), https://www.dispatch.com/news/20200405/coronavirus-amid-scarce-resources-ohio-not-ready-to-decide-who-gets-treated-first.

[40] Even in regions with highly developed health systems, COVID-19 is straining ability to care, creating cause for alarm for less-equipped health care systems in regions that do not act to mitigate risk of infection. *See* Jason Horowitz, *Italy's Health Care System Groans Under Coronavirus – a Warning to the World*, N.Y. TIMES (Mar. 12, 2020), https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html.

area and are not allowed to leave the unit at all. Thus, even if a detainee is not currently sharing a cell, they cannot maintain 6 feet of distance from other detainees at all times. There are also either no windows or windows that do not open at all, meaning little to no access to fresh air.

37. The declarations also describe observing facility staff members working at Geauga and Seneca, including preparing food and delivering medication, without always wearing masks, gloves, or other protective gear. Detainees themselves are not provided masks, even if they have symptoms like coughing. Bathrooms, which are also shared, are generally dirty and not regularly cleaned. Detainees are therefore unable to practice social distancing or other measures to protect themselves from exposure to staff and various surfaces in the facility.

38. According to the declarations, detained individuals are also not provided with necessary cleaning materials to protect themselves, such as hand sanitizer, gloves, masks, or other personal protective equipment. They are not always provided with sufficient free soap or sufficient paper towels.

39. Ms. Starda's declaration on behalf of Mr. Amaya-Cruz also describes multiple people sick with coughs in his dorm who have been returned to the general population, and there is no indication that these individuals have been tested for COVID-19.

40. Ms. Pascalenco's declaration describes having recently shared a cell with two other detainees, one of whom had been ill with a fever and cough.

41. I have also reviewed the declarations of the following individuals: Corrylee Drozda, an attorney who regularly visits the Geauga facility, most recently on March 4, 2020, and has been in direct contact with three clients detained at Geauga; and, Julie Burnett, a legal assistant working for a nonprofit who speaks with clients and pro se detainees daily by phone about the conditions at Seneca.

42. Conditions as described in these declarations reinforce the high risk of COVID-19 transmission at the Geauga and Seneca facilities.

43. Based upon Ms. Drozda's declaration regarding Geauga, detainees are not protected from COVID-19. Specifically,
    a) A female client is held in one pod with a total of 10 women, where they share a common area and rooms that do not provide enough space to social distance from a cell mate.
    b) Detainees have not been provided with any masks or gloves.
    c) No changes have been made to the cleaning or sanitation procedures since the COVID-19 pandemic.
    d) Through her clients, she is unaware of any testing for COVID-19 taking place. If an individual needs medical attention, they must submit a "kite" or note to the medical staff, and wait up to three days for a response.
    e) Seneca staff have not provided detainees information about the jail's response to the pandemic. What little information is provided by ICE is communicated only in English.

44. Based on Ms. Burnett's declaration regarding Seneca, detainees live in tight quarters and are unable to practice social distancing or other measures to protect themselves from COVID-19. Specifically,
    a) Detained individuals are housed in pods that consist of open, concrete, dormitory-style rooms where an entire group of people eats, sleeps and has all their recreation time together.
    b) Two of Ms. Burnett's clients are detained in a pod with a total of 35 men who share bunk beds that are less than 6 feet apart.
    c) The showers and toilet facilities were shared by a large number of people, and are never cleaned by the staff. Detainees who wish to clean must do so with their own personal hygiene products.
    d) In general, sanitation measures, including access to soap, are inadequate.

45. Based upon the information provided to me, and my prior knowledge of detention facilities, the Geauga and Seneca facilities do not have the ability to implement the critically important principle of social distancing, such as maintain six feet of separation at all times including meals and location of beds, nor are they apparently taking extraordinary measures to identify and properly isolate individuals at high risk, those with potential exposure or those with symptoms consistent with COVID-19. These steps are essential to preventing transmission of COVID-19. Where immigration detention facilities are housing detained individuals in cells or dormitories in which the beds are close together and where they are crowded together to eat meals, they will not be able to prevent COVID-19 transmission once introduced into the facility. Upon review of the declarations, the facility also does not appear to have sufficient supplies available for detainees for handwashing or disinfecting. Further, through recreation and staff, detainees at each of these facilities are at risk of being exposed to COVID-19.

46. Introduction of new people into detention facilities who have had contact with the community outside the facility—be it officers and other staff or new individuals coming into detention—creates a link from transmission occurring in the community to those who are detained. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection.

47. The alternative is to test all staff and detainees entering the facility. However, this would require frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities (that included nearby Akron, Cleveland, and Toledo as well as other Ohio cities), 92.1% of cities reported that they do not have an adequate supply of test kits.[41] Shortages are likely to become more severe over the next three to four weeks when there will be a major shortage of

[41] *Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation's Mayors*, UNITED STATES CONFERENCE OF MAYORS, https://www.usmayors.org/issues/covid-19/equipment-survey/ (last visited Apr. 2, 2020).

chemical reagents for COVID-19 testing and enormous increases in demand.[42] Given the shortage of COVID-19 testing in the United States, it is likely that immigration detention centers are and will continue to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history– all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place.

ICE's Guidance is Insufficient

48. I have reviewed the ICE guidance on its website on COVID-19, updated on April 9, 2020,[43] and ICE's protocol for a clinical response ("Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)" version 6.0 issued March 6, 2020).[44] I have also reviewed the March 27, 2020 Memo entitled "Memorandum on Coronavirus Disease (COVID-19) Action Plan, Revision 1" ("ICE Action Plan"), from Enrique M. Lucero, Executive Associate Director, Enforcement and Removal Operations, addressed to Detention Wardens and Superintendents.[45]

49. Based on my training and decades of professional experience in public health, the procedures described therein are entirely inadequate to prevent or mitigate the rapid transmission of COVID-19 in Geauga and Seneca. I am unaware of any epidemiologist or any public health expert who would consider these procedures to be sufficient preventive measures. The protocols do not address widespread community infection, imminent shortages of medical supplies and staffing or education of detained people and staff about the virus, amongst other critical issues.
    a. On March 24, ICE announced its first confirmed case of COVID-19 amongst its detainees.[46] About two weeks later, ICE reports that as of April 9, there were 48 confirmed cases of COVID-19 among ICE detainees, 15 cases among ICE detention facility employees (including 1 in Ohio), and 65 cases among ICE employees not currently assigned to detention facilities.[47] On April 3, after nearly 23 years of housing immigration inmates for the federal government, the Monroe County (FL) detention center "abruptly severed" its

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[42] Michael T. Osterholm & Mark Olshaker, Opinion, *It's Too Late to Avoid Disaster, but There Are Still Things We Can Do*, N.Y. TIMES (Mar. 27, 2020), https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html.

[43] *ICE Guidance on COVID-19*, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, https://www.ice.gov/coronavirus (last updated Apr. 9, 2020).

[44] *Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)*, ICE HEALTH SERVICE CORPS (Mar. 6, 2020), *available at* https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus.

[45] *Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision I*, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT (Mar. 27, 2020) on file with the author.

[46] *News Release: ICE Detainee Tests Positive for COVID-19 at Bergen County Jail*, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT (Mar. 24, 2020), https://www.ice.gov/news/releases/ice-detainee-tests-positive-covid-19-bergen-county-jail.

[47] *ICE Guidance on COVID-19*, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, https://www.ice.gov/coronavirus (last updated Apr. 9, 2020) (under "Confirmed Cases").

contract with U.S. Immigration and Customs Enforcement, as a result of concerns about housing immigration detainees with jail inmates due to potential SARS-CoV-2 transmission.[48]

b. As of April 9, 2020, Geauga and Seneca Counties have reported 54 cases and 2 deaths due to COVID-19 in total.[49] These are likely underestimates. It is reasonable to expect this kind of introduction of COVID-19 into Montgomery Processing Center from staff exposed in the community given the current local transmission of COVID-19 in Montgomery County and given that a staff member has already tested positive at the facility.

50. Social distancing is the primary way to mitigate risk of COVID-19 infection and spread. The CDC guidance for detention facilities states: "Although social distancing is challenging to practice in correctional and detention environments, it is ***a cornerstone of reducing transmission*** [emphasis added] of respiratory diseases such as COVID-19". Social distancing, simply understood in the context of COVID-19 is keeping individuals six feet away (in all directions) from one another. It is also the basis for the extraordinary measures being taken nationwide to restrict movement and contact from individuals in the community. The CDC outlines the following social distancing steps for detention facilities, which include reassigning sleeping arrangements to provide 6 feet or more of space in all directions, spacing seating in the dining areas so that people remain 6 feet apart while eating, and designating rooms near each housing unit to evaluate individuals with COVID-19 symptoms so that they do not walk through the facility for medical evaluation.[50] The declarations I previously reviewed from the individuals housed in the facilities identify multiple violations of the CDC guidance on social distancing. Given the population sizes in the facilities, the limited amounts of physical space, increasingly limited staffing as staff are in self-quarantine, and the security measures that require staff and detained individuals to come into contact, it is my belief that it will not be possible to implement the CDC-recommended measures at Geauga or Seneca facilities.

51. In respect to ICE guidance,[51] the screening procedures described will not protect Plaintiffs from COVID-19. The protocols do not address widespread community infection, imminent shortages of medical supplies and staffing or education of detained people and staff about the virus, amongst other critical issues.

a. Screening measures will not be sufficient to identify infected individuals who come in because of asymptomatic transmission and community spread that makes asking about past contacts insufficient. Given the nationwide shortage of testing equipment and laboratories, ICE's screening inquiry regarding whether a detainee

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[48] Monique O. Madan, *Amid COVID-19 Fears, Keys Jail Ends Lucrative Contract, Gives ICE Back Its Detainees*, MIAMI HERALD (updated Apr. 6, 2020), https://www.miamiherald.com/news/local/immigration/article241783926.html.

[49] *State of Ohio: COVID-19 Dashboard (County Map)*, OHIO DEPARTMENT OF PUBLIC HEALTH (last accessed Apr. 9, 2020), https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards.

[50] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTER FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last updated Mar. 23, 2020).

[51] *See* Para. 49, *supra*, and footnotes therein.

has had close contact with a person with laboratory- confirmed COVID-19 in the past 14 days is inadequate to properly assess the detainee's potential exposure to the virus. This inquiry is particularly egregious given known wealth disparities in access to testing. Asking about travel through areas with sustained community transmission is also insufficient: given community spread, it is likely that almost everyone in the general public who is not practicing social distancing is in contact with the COVID-19 virus.

b. Enhanced screening is identified as verbal screening and temperature checks. However, we know that this is insufficient due to both presymptomatic transmission and the absence of fever in some symptomatic, and infected, individuals.

c. Importantly, there is no guidance in the protocol to identify high-risk patients or steps to protect them from contracting COVID-19, other than cohorting high-risk individuals, a practice which will likely facilitate rather than prevent spread of COVID-19 in the absence of adequate social distancing and sanitation measures. Screening measures will not be sufficient to identify infected individuals who come into ICE facilities because of presymptomatic transmission and community spread that makes asking about past contacts insufficient.

d. The protocol does not address how the facilities are to account for the large number of people who have potentially already been exposed to COVID-19. For example, the protocol does not provide for masks for individuals with a cough. It states that people with suspected COVID-19 contact will be monitored for 14 days with symptom checks. The protocol is written as if this is a rare occurrence, reflecting smaller outbreak management, but the prevalence of COVID-19 is now growing to such an extent that a large share of newly arrived people may have recent contact with someone who is infected. ICE would need to use this level of monitoring for every person arriving in detention. Accordingly, ICE would need to dramatically expand its medical facilities and staffing to conduct this daily monitoring of every newly arrived person for 14 days. It would also need the physical infrastructure in which to isolate these individuals. The protocol fails to contemplate these necessary changes.

e. The protocol also does not account for the fact that staff are coming into the facility daily from affected communities, making them an especially important vector in this outbreak. Given asymptomatic transmission, to effectively screen staff, the facilities would have to conduct frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities (that included Akron, Cleveland and Toledo among other Ohio cities), 92.1% of cities reported that they do not have an adequate supply of test kits.[52] Shortages are likely to become more severe over the next three to four weeks when there will be a major shortage of chemical reagents for COVID-19

[52] *Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation's Mayors*, UNITED STATES CONFERENCE OF MAYORS, https://www.usmayors.org/issues/covid-19/equipment-survey/ (last visited Mar. 28, 2020).

testing and enormous increases in demand.[53] Given the shortage of COVID-19 testing in the United States, it is likely that immigration detention facilities are and will continue to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19.

f. The "ICE Action Plan" states that "Wardens and Facility Administrators should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice." The memo is correct to emphasize maximizing social distancing, however these suggested steps fall short of what is necessary to prevent transmission if SARS-CoV-2 is introduced and say nothing about crowding in housing units.

g. The protocol fails to include guidance for health staff or administrators regarding how to plan their surge capacity needs as the level of medical encounters increases, and the number of available staff decreases, due to illness. This is a critical component of the CDC guidance on long term care response and is a critical omission in this protocol. There is no guidance for clinical staff on when to test patients for COVID- 19, which leaves detained patients at a significant disadvantage. While the guidelines for testing may evolve over time, the protocol should create a structure for daily dissemination of testing criteria from ICE leadership, and time for daily briefings among all health staff at the start of every shift, to review this and other elements of the COVID-19 response. This briefing must include participation by epidemiologists tasked to COVID- 19 response who are also coordinating with local and federal COVID-19 activities.

h. Although the protocol states that "In other cases, including when a detainee requires a higher level of care, they are sent to a local hospital…" in practice the transfer of suspected COVID-19 positive patients, under strict isolation conditions, at the anticipated number of cases in need of testing would potentially put detention staff at risk and overburden available detention facility staff. As clinical staff have no experience with this disease, ICE should develop rational clinical criteria for transfer to an acute care hospital.

i. The ICE protocol provides no guidance about identification of high-risk patients at the time of entry or any special precautions that will be enacted to protect them. The protocol also fails to address the identification of high-risk patients who have already been admitted. Because the ICE response fails to create increased protections for people with risk factors for serious illness and death from COVID-19, they are unlikely to detect illness in these patients until many of them are critically ill. As with the lack of guidance on testing, this lack of clear guidance on how to determine who meets criteria for hospital transfer may prove deadly for detained people.

j. It is my view that the protocol is crafted to address a relatively small and time-limited outbreak and lacks anticipation of what has already started elsewhere and will soon impact these facilities, including widespread infection of both

[53] Michael T. Osterholm & Mark Olshaker, Opinion, *It's Too Late to Avoid Disaster, but There Are Still Things We Can Do*, N.Y. TIMES (Mar. 27, 2020), https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html.

detainees and staff with a massive impact on the level of staffing and capacity for clinical care. ICE must release all people with risk factors to prevent serious illness including death. The lack of specific attention to date in ICE's guidance on COVID-19 indicates that they do not plan to establish special protections for high-risk patients, instead waiting for them to become symptomatic. This will lead to unnecessary illness and death for the people most vulnerable to this disease.

k. The current outbreaks across the country should be a cautionary example of infectious spread in these congregate environments. It has been estimated that at least 32 deaths and 1,324 confirmed coronavirus cases have occurred among inmates and staff at US prisons and jails.[54] In Cook County Jail, Chicago in a matter of two days, the number of individuals infected jumped from 38 inmates[55] to 89 inmates and 12 staff members.[56], As of April 1, there were 167 confirmed cases among detained individuals, even after the jail released 400 individuals.[57] On April 8, the Cook County Sheriff's Office said that 238 inmates and 115 staff members had tested positive. These numbers are likely an underestimate as the jail acknowledged that the "vast majority" of the jail's inmates have not been tested.[58] At Rikers Island in New York, on Saturday March 21, a jail oversight agency indicated that 21 inmates and 17 employees tested positive.[59] As of April 5, 273 inmates at Rikers and 321 correctional staff across the New York City jail system had tested positive for COVID-19; 1 inmate and 4 corrections officers have died.[60] **The Legal Aid Society in New York recently reported that the infection rate for COVID-19 at local jails is more than seven times higher than the rate citywide and 87 times higher than the country at large.[61]**

52. ICE's procedures upon identification of a positive test case also do not address key components of the CDC's guidance aimed at limiting spread within detention facilities. The procedures for isolation state: "ICE places detainees with fever and/or respiratory symptoms in a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents, such as COVID-19." These procedures would be sufficient to address a limited number of infected

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[54] Timothy Williams and Danielle Ivory, *Chicago's Jail Is Top U.S. Hot Spot as Virus Spreads Behind Bars*, N.Y. TIMES (Apr. 9, 2020), https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html.0

[55] *Cook County Jail Says 17 Inmates Have Tested Positive for Coronavirus*, NBC CHICAGO (last updated Mar. 25, 2020), https://www.nbcchicago.com/news/local/cook-county-jail-says-17-inmates-have-tested-positive-for-coronavirus/2244652/.

[56] Josh Gerstein, *Federal Prisons Mark First Virus Death*, POLITICO (Mar. 29, 2020), https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387.

[57] *167 Cook County Jail Detainees Have Tested Positive for COVID-19, Officials Say*, NBC CHICAGO (Apr. 1, 2002), https://www.nbcchicago.com/news/local/167-cook-county-jail-detainees-have-tested-positive-for-covid-19-officials-say/2248892/.

[58] *See supra*, n.54.

[59] *21 Inmates, 17 Employees Test Positive for COVID-19 on Rikers Island: Officials*, NBC NEW YORK (Mar. 21, 2020), https://www.nbcnewyork.com/news/coronavirus/21-inmates-17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242.

[60] Josiah Bates, *New York's Rikers Island Jail Sees First Inmate Death From COVID-19*, TIME (Apr. 6, 2020), https://time.com/5816332/rikers-island-inmate-dies-coronavirus/..

[61] *Coronavirus Update: Rikers Island Rate of Infection 7 Times Higher Than Citywide, Legal Aid Says*, CBS NEW YORK (Mar. 26, 2020, 5:24 PM), https://newyork.cbslocal.com/2020/03/26/coronavirus-rikers-island.

individuals. However, many facilities only have 1-4 of these medical rooms available in the facility. Given the rate of spread in detention facilities, there will be many more than 1-4 people with COVID-19 in the detention centers. This limited physical infrastructure will mean that ICE cannot comply with this protocol.

53. I believe that ICE has taken some steps in response to COVID-19. ICE guidance mentions such steps as suspending inmate visits, increasing sanitization of certain areas, and the provision of hand sanitizer to inmates. **However, none of these steps are adequate to mitigate the transmission of the virus in the absence of social distancing measures and without vastly better monitoring and isolation procedures of detainees and screening of staff.** Even in the best scenario, given the physical infrastructure of facilities, the challenges of providing security without close contact, and the lack of proper equipment (such as masks) to prevent transmission, I do not believe detention facilities are equipped to ensure the safety of those in their custody. While there are risks to individuals in the community, releasing individuals at highest risk who can then self-isolate – either in their homes or in facilities arranged by the local department of health – provides a significantly better likelihood of preventing infection, disease spread and death, both in the facility and in the community at large.

Conclusions

54. CDC guidance on correctional and detention facilities,[62] reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at "heightened" risk for COVID-19 infection once the virus is introduced; 2) There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

55. Immigration detention facilities cannot follow CDC guidelines for detention facilities where people are double and triple-celled, housed in large rooms where people are forced into close contact, and where people are sharing common facilities like bathrooms that cannot be properly sanitized given the sheer numbers of people using them in a day. Detained individuals will not be able to practice social distancing and facilities cannot ensure adequate sanitation measures. Where quarantine is necessary, it will not be possible to isolate individuals from each other where there are so many people in a confined space.

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[62] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTER FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last updated Mar. 23, 2020).

56. To effectively mitigate risk of infection and subsequent spread, the population will need to be reduced. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees, and allow individuals who are infected, and their close contacts, to be properly isolated or quarantined in individual rooms, according to the CDC's preferred practices, and properly monitored for health complications that may require transfer to a local hospital. It will also lessen the risk to corrections officers, who if short staffed, will have difficulty maintaining order and proper personal protective measures. Protecting corrections staff in turn protects the communities they come from.

57. The release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is also a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

58. Individuals who are close contacts of people who have been infected with SARS-CoV-2 should be tested to determine if they are infected. Those who test positive should be continuously monitored in individual rooms, released to home quarantine or transferred to local hospitals if medically indicated. Those who test negative should be allowed to self-quarantine at home, if at all possible, or at housing identified by health authorities.

59. Current conditions and procedures in place at the Geauga and Seneca detention Facilities, as described by plaintiff and other fact declarations, are insufficient to prevent the introduction of COVID-19 or prevent its rapid transmission among both detainees and staff. One ICE facility staff member, at Butler County Jail in Hamilton OH, has already tested positive for COVID-19.[63] The lack of daily tests of staff who have ongoing community contacts presents a risk of introduction of the virus into the detention facility. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is also inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history– all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place. The crowded conditions, in both sleeping areas and social areas, and the shared objects (bathrooms, sinks, etc.) will facilitate transmission.

60. Other individuals who may not be identified as high risk should also be considered for release. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees and lessen the burden of ensuring the safety of detainees and corrections officers.

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[63] *See https://www.ice.gov/coronavirus accessed April 9, 2020*

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

Executed this 10th day of April 2020 in Princeton, New Jersey.

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EDUCATION

08/1998-10/2002	Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine *PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya*	Bethesda, MD
08/1991-12/1994	Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health & Tropical Medicine *MSPH, Tropical Medicine*	New Orleans, LA
08/1987-05/1991	Hampshire College *BA, Interdisciplinary Studies*	Amherst, MA

ACADEMIC APPOINTMENTS

9/2018 – Present	Dornsife School of Public Health, Drexel University *Director, Global Health* *Clinical Professor, Dept of Community Health and Prevention*	Philadelphia, PA
01/2010 – Present	Dept. of Epidemiology and Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins *Associate*	Baltimore, MD
09/2010 – 06/2018	Woodrow Wilson School of Public and International Affairs, Princeton University *Visiting Lecturer*	Princeton, NJ
01/2015 – 05/2018	Dept. of Epidemiology, Mailman School of Public Health, Columbia University *Adjunct Associate Professor*	New York, NY
06/2014 – 07/2014	School of Social Science, Institute for Advanced Study *Short-term Visitor*	Princeton, NJ
09/2012 – 12/2012	Institut d'Études Politiques de Paris (SciencesPo) *Distinguished Visiting Lecturer*	Paris, France
01/2003–06/2007	Dept. of Preventive Medicine, Hebert School of Medicine, Uniformed Services University of the Health Sciences *Adjunct Assistant Professor*	Bethesda, MD

TEACHING EXPERIENCE

Professor		
2019 - Present	Drexel University	Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate)
2011 – 2018	Princeton University	Health and Human Rights (undergraduate) Epidemiology (undergraduate)
09-12/2012	SciencesPo	Health and Human Rights (graduate)
Co-Instructor		
2012-2013	Global School of Socioeconomic Rights, Harvard University	Health Rights Litigation (graduate)

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

09/2019 – Present	Senior Editor, Health and Human Rights Journal
01/2010 – Present	Journal of the International AIDS Society, Editorial Board
07/2012 – Present	Journal of the International AIDS Society, Ethics Committee
01/2015 – 07/2016	Co-Editor, The Lancet HIV Special Issue on HIV and Prisoners
09/2017 – 06/2018	Co-Editor, Health and Human Rights Journal Special Issue on NTDs and Human Rights

Advisory

09/2016 – Present	The Global Fund, Working Group on Monitoring and Evaluating Programmes to Remove Human Rights Barriers to HIV, TB and Malaria Services
12/2014 – Present	UNAIDS, Strategic and Technical Advisory Group
07/2008 – Present	UNAIDS, HIV and Human Rights Reference Group (co-chair Aug 2014 – present)
06/2012 – 6/2018	Global Institute for Health and Human Rights, University at Albany, International Advisory Board
02/2012 – 01/2016	Founding member, Coalition for the Protection of Health Workers in Armed Conflict
01/2014 – 01/2016	Founding member: Robert Carr Award for Research on HIV and Human Rights
07/2011 – 07/2012	XIX International AIDS Conference, Scientific Programme Committee
11/2009 – 09/2012	WHO/STOP TB Partnership, TB and Human Rights Task Force

FULL-TIME WORK EXPERIENCE

09/2018-Present — **Drexel University, Dornsife School of Public Health,** *Philadelphia, PA.*
- *Director, Global Health*
- *Clinical Professor, Dept of Community Health and Prevention*

02/2016–08/2018 — **Helen Keller International,** *New York, NY.*
- *Vice President, Neglected Tropical Diseases*

Provided strategic, technical and overall management for >$125m portfolio of work on NTDs. Led development of proposals resulting in >$80m in new projects.

08/2005–01/2016 — **Human Rights Watch,** *New York, NY.*
- *Director, Health Division (Sept 2008 – Jan 2016)*
- *Founded Disability Rights Division (2013); Environment Division (2015)*
- *Director, HIV/AIDS Program (August 2005 – August 2008)*

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.

07/2003–06/2005 — **Centers for Disease Control and Prevention,** *Atlanta, GA.*
- *Epidemiologist, EIS Officer*

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.

07/2000–09/2002 — **Walter Reed Army Institute of Research,** *Silver Spring, MD.*
- *Research Fellow*

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.

07/1995–06/1998 — **Family Health International,** *Arlington, VA.*
- *Technical Officer (Jan – June 1998)*
- *Evaluation Officer (Aug 1996 – Dec 1997)*
- *Associate Evaluation Officer (July 1995 – July 1996)*

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.

09/1992–11/1994 — **U.S. Peace Corps,** *Lomé, Togo.*
- *Volunteer*

Designed and implemented process monitoring system for national Guinea Worm eradication program. Conducted health education training. Supervised village health workers.

SHORT-TERM AND CONSULTING EXPERIENCE

Human Rights Watch, *New York, NY.*	Provide technical review for research design, analysis and documents related to health and environment and human rights.	Sept 2018 – Present
The Futures Group International, *REACH Project, Washington DC.*	Co-investigator for HIV/AIDS operations research related to orphans and vulnerable children and adolescent-oriented HIV volunteer counseling and testing.	Mar 2002 – June 2003
Walter Reed Army Institute of Research, *Silver Spring, MD.*	Developed database and provided statistical support to malaria vaccine clinical trial project.	Apr 2002 – June 2003
John Snow, Inc., *Arlington, VA.*	Developed curriculum and provided training on HIV/AIDS monitoring and evaluation to Ministry of Health staff from 8 countries.	Dec. 2002 – June 2003
TvT Associates, *SYNERGY Project, Washington, DC.*	Designed $20+ million comprehensive HIV/AIDS strategy for USAID Ukraine and USAID Russia.	Dec. 2001 – April 2003
PACT, *Washington, DC.*	Designed outcome and impact evaluation of HIV behavioral intervention project.	June 2002
Encompass LLC, *Bethesda, MD.*	Designed evaluation of World Bank health sector reform training.	January – May 2002
U of Washington, *Center for Health Education and Research.*	Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.	April – May 2002
Family Health International, *Arlington, VA.*	Analyzed HIV-related behavioral surveillance results from studies in Honduras, Nigeria, Ghana, and Senegal.	Sept 1998 – Mar 2002
Datex Inc., *Falls Church, VA.*	Provided expert review for USAID-funded HIV/AIDS behavioral intervention grants competition.	May– Jun 2001 Jan – Feb 2000
PLAN International *Bamako, Mali and Arlington, VA.*	Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.	May – Dec 2000
Ministry of Health, *Kingston, Jamaica.*	Analyzed behavioral surveillance results and facilitated workshop examining HIV trends.	Oct 1998
Eli Lilly Foundation, *Diabetes Control Program, Accra, Ghana.*	Designed and implemented outcome and impact evaluation of diabetes prevention and care program.	Sept 1996
Carter Center, *Niger Guinea Worm Eradication Program, Zinder, Niger.*	Designed and implemented outcome and impact evaluation of guinea worm eradication program.	Mar – May 1995

PEER REVIEW JOURNAL PUBLICATIONS

1 Kotellos KA, **Amon JJ**, Githens Benazerga W. *Field Experiences: measuring capacity building efforts in HIV/AIDS prevention programmes.* AIDS 1998; 12 (supl 2):109-17.

2 Figueroa JP, Brathwaite AR, Wedderburn M, Ward E, Lewis-Bell K, **Amon JJ**, Williams Y, Williams E. *Is HIV/STD control in Jamaica making a difference?* AIDS 1998; 12 (supl 2):S89-S98.

3 Hayman JR, Hayes SF, **Amon J**, Nash TE. *Developmental expression of two spore wall proteins during maturation of the microsporidian Encephalitozoon intestinalis*. Infect Immun 2001; 69(11):7057-66.

4 **Amon JJ**. *Preventing HIV Infections in Children and Adolescents in Sub-Saharan Africa through Integrated Care and Support Activities.* African Journal on AIDS Research. 2002; 1(2):143-9.

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50 Hamdi H, Ba O, Niang S, Ntizimira C, Mbengue M, Coulbary AS, Niang R, Parsons M, **Amon JJ**, Lohman D. *Palliative Care Need and Availability in Four Referral Hospitals in Senegal: Results from a Multi-Component Assessment.* Journal of Pain and Symptom Management. 2017 Dec 7.

51 Traoré L, Dembele B, Keita M, Reid S, Dembéle M, Mariko B, Coulibaly F, Goldman W, Traoré D, Coulibaly D, Guindo B, **Amon JJ**, Knieriemen M, Zhang Y. *Prevalence of trachoma in the Kayes region of Mali eight years after stopping mass drug administration.* PLoS neglected tropical diseases. Feb 2018;12(2):e0006289.

52 Biehl J, Socal MP, Gauri V, Diniz D, Medeiros M, Rondon G, **Amon JJ**. *Judicialization 2.0: Understanding right-to-health litigation in real time.* Global Public Health. May 2018 22:1-0.

53 Sun N and **Amon JJ**. *Addressing Inequity: Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

54 **Amon JJ**, Addiss D. *"Equipping Practitioners": Linking Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

55 Géopogui A, Badila CF, Baldé MS, Nieba C, Lamah L, Reid SD, Yattara ML, Tougoue JJ, Ngondi J, Bamba IF, **Amon JJ**. Baseline trachoma prevalence in Guinea: Results of national trachoma mapping in 31 health districts. PLoS neglected tropical diseases. June 2018; 12(6):e0006585.

56 Coltart CE, Hoppe A, Parker M, Dawson L, **Amon JJ**, Simwinga M, Geller G, Henderson G, Laeyendecker O, Tucker JD, Eba P. Ethical considerations in global HIV phylogenetic research. The Lancet HIV. Aug 2018

57 **Amon JJ**, Eba P, Sprague L, Edwards O, Beyrer C. Defining rights-based indicators for HIV epidemic transition. PLoS medicine. Dec 2018; 15(12):e1002720.

58 Bah YM, Bah MS, Paye J, Conteh A, Saffa S, Tia A, Sonnie M, Veinoglou A, **Amon JJ**, Hodges MH, Zhang Y. *Soil-transmitted helminth infection in school age children in Sierra Leone after a decade of preventive chemotherapy interventions.* Infectious diseases of poverty. 2019 Dec;8(1):41.

59 Addiss DG, **Amon JJ**. *Apology and Unintended Harm in Global Health.* Health and Human Rights. 2019 Jun;21(1):19.

60 Socal MP, **Amon JJ**, Biehl J. *Institutional Determinants of Right-to-Health Litigation: The Role of Public Legal Services on Access to Medicines in Brazil.* Global Public Health. (in press)

61 Ward E, Hannass-Hancock J, **Amon JJ**. *Invisible: The Exclusion of Persons with Disabilities from HIV Research and National Strategic Plans in East and Southern Africa.* (Article: submitted)

BOOK CHAPTERS

1 **Amon J**. *Africa, Southern* in: Encyclopedia of AIDS, Ray Smith, ed. Chicago: Fitzroy Dearborn Publishers, 1998.

2 **Amon JJ**, Kotellos KA, Githens Benazerga W. *Evaluating Capacity Building*. HIV/AIDS Prevention and Control Synopsis Series. Family Health International, Arlington, VA: 1997.

3 **Amon JJ,** Saidel TJ, Mills S. *Behavioral Surveillance Survey Methodology: Experiences from Senegal and India.* WHO/UNAIDS Best Practices Series. WHO/UNAIDS. Geneva, June 2000.

4 **Amon J**, Brown T, Hogle J, MacNeil J, et al. *Behavioral Surveillance Surveys: Guidelines for repeated behavioral surveys in populations at risk of HIV*. FHI/IMPACT, USAID, DFID Publication. August 2000.

5 Kolars-Sow C, Saidel T, Hogle J, **Amon J**, Mills S. Indicators and questionnaires for behavioral surveys. In: Rehle T, Saidel T, Mills S, and Magnani R., (eds.) Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers. Family Health International, Arlington, VA. August 2001.

6 **Amon JJ**, Bond KC, Brahmbhatt MN, *et al*. *Bellagio Principles on Social Justice and Influenza.* Johns Hopkins. Berman Institute of Bioethics. July 2006.

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8 **Amon J**. *High Hurdles for Health.* In: M. Worden (ed.) China's Great Leap: The Beijing Games and Olympian Human Rights Challenges. Seven Stories Press. May 2008.

9 **Amon J.** *Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights.* In: N. Sudarshan (ed.) HIV/AIDS, Health Care and Human Rights Approaches. Amicus Books. Jan 2009.

10 **Amon J.** *Abusing Patients.* In: Human Rights Watch, 2010 World Report. New York: Seven Stories Press. Jan 2010.

11 **Amon JJ** and Kasambala T. Structural barriers and human rights related to HIV prevention and treatment in Zimbabwe. In: M. Seglid and T. Pogge (eds) Health Rights. London: Ashgate. Oct 2010.

12 **Amon JJ.** *HIV and the Right to Know: Whose right to know what? The discourse of human rights in the global HIV response*. In: J. Biehl and A. Petryna (eds.) "When people come first: Anthropology and social innovation in global health". Princeton: Princeton University Press. July 2013.

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14 **Amon JJ** and Friedman E. *Human Rights Advocacy for Global Health*. In: LO Gostin and BM Meier (eds) "Foundations of Global Health & Human Rights". New York: Oxford University Press. 2020

EDITORIAL/COMMENT

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4 Thomas L, Lohman D, **Amon J**. *Doctors take on the state: championing patients' right to pain treatment.* Int J Clin Pract. 2010, 64(12):1599-600.

5 **Amon J.** *HIV Treatment as Prevention – Human Rights Issues.* Journal of the International AIDS Society. 2010, 13(Suppl 4):O15

6 **Amon JJ**. *Hepatitis in Drug Users: Time for Attention, Time for Action.* Lancet, 2011, 378(9791):543-4

7 **Amon J**, Lohman D. *Denial of Pain Treatment and the Prohibition of Torture, Cruel, Inhuman or Degrading Treatment or Punishment.* Interrights Bulletin, 2011, Vol 16: 4.

8 **Amon J**. *Justice Delayed, Health Denied*. The Scientist. June, 2012.

9 Kyoma M, Todrys KW, **Amon JJ**. *Laws against sodomy and the HIV epidemic in African prisons.* Lancet, 2012, *380 (9839): 310 - 312*

10 Pearshouse R, **Amon JJ**. *The Ethics of Research in Compulsory Drug Detention Centers in Asia.* Journal of the International AIDS Society. 2012, 15:18491

11 Wurth MH, Schleifer R, McLemore M, Todrys KW, **Amon JJ**. *Condoms as Evidence of Prostitution in the US and the Criminalization of Sex Work.* Journal of the International AIDS Society. 16(1): 10.7448/IAS.16.1.18626.

12 **Amon JJ.** *Political Epidemiology of HIV.* Journal of the International AIDS Society. 2014, 17:19327

13 **Amon JJ.** *Law, Human Rights and Health Databases: A roundtable discussion.* Health and Human Rights Journal. September 2014.

14 Otremba M, Berland G, **Amon JJ.** *Hospitals as Debtor Prisons.* The Lancet Global Health. 3, 5: e253–e254, May 2015.

15 Beyrer C, Kamarulzaman A, McKee M, for the Lancet HIV in Prisoners Group (incl. **Amon JJ**). *Prisoners, prisons, and HIV: time for reform.* The Lancet. 2016 Jul 14.

16 **Amon JJ**. *The impact of climate change and population mobility on neglected tropical disease elimination*. International Journal of Infectious Diseases 53 (2016): 12.

17 **Amon JJ.** *WHO Focus on Human Rights: Will it Extend to Neglected Tropical Diseases?* Health and Human Rights Journal. Nov 2017.

18 Groves, A, Maman S, Stankard PH, Gebrekristos LT, **Amon JJ,** Moodley D. *Addressing the unique needs of adolescent mothers in the fight against HIV*. Journal of the International AIDS Society.

19 **Amon JJ**, Sun N. *Subverting Rights: Addressing the Increasing Barriers to Reproductive Rights.* Health and Human Rights Journal. May 2018.

20 Biehl J, **Amon JJ**. *The Right to Remedies: On Human Rights Critiques and Peoples' Recourses.* Humanity Journal. Oct 2019

21 Williams C, **Amon JJ**, Bassett MT, Roux AV, Farmer PE. *25 Years: Exploring the Health and Human Rights Journey*. Health and Human Rights. 2019 Dec;21(2):279.

22 **Amon JJ**, Sun N. *HIV, human rights and the last mile.* Journal of the International AIDS Society. 2019 Dec 1;22(12).

23 **Amon JJ**. *Ending discrimination in healthcare.* Journal of the International AIDS Society. 2020 Feb;23(2).

LETTERS

1 **Amon JJ.** *The HIV/AIDS Epidemic in Ukraine: stable or still exploding?* Sexually Transmitted Infections. 2003 79(3):263-4.

2 Lohman D, **Amon JJ**. *HIV Testing*. Lancet. 2008 Feb 16;371(9612):557-8.

3 Root B, Levine I, **Amon JJ**. *Counting and Accountability*. Lancet. 2008 Jan 12;371(9607):113.

4 Tarantola D, **Amon J**, Zwi A, Gruskin S, Gostin L. *H1N1, public health security, bioethics, and human rights.* Lancet. 2009 Jun 20;373(9681):2107-8

5 Hsieh A, **Amon JJ**. *Ratification of human rights treaties: the beginning not the end.* Lancet. 2009 Aug 8;374(9688):447

6 **Amon J**, Lohman D, Thomas L. *Access to pain treatment a luxury for most.* Lancet 2009 Nov 14; 374:1676

7 **Amon J**. *Harm reduction and the Catholic Church.* Conscience. Winter 2010.

8 **Amon J.** *Human Rights Abuses, Ethics, and the Protection of Subjects When Conducting Research on Intravenous Drug Users in China.* JAIDS: Journal of Acquired Immune Deficiency Syndromes. June 2011.

9 Cohen EJ, **Amon JJ**. *Lead Poisoning in China.* Lancet, 2011, 378(9803):e3.

10 **Amon JJ.** *Chinese Addiction Study and Human Rights.* Science, 2012, 337:522-523.

11 Pearshouse R and **Amon JJ.** *Human Rights and HIV Interventions in Chinese Labour Camps.* Sex Transm Infect. doi:10.1136/sextrans-2015-052193

12 Biehl J, **Amon JJ**, Socal M, Petryna A. *The Challenging Nature of Gathering Evidence and Analyzing the Judicialization of Health in Brazil.* Cadernos de Saúde Pública. July 2016.

13 Biehl J, Socal M, **Amon JJ**. *On the Heterogeneity and Politics of the Judicialization of Health in Brazil.* Health and Human Rights Journal. Dec 2016.

14 **Amon J**. *Re: Attacks on Ebola Health Workers in the Democratic Republic of Congo.* New York Times. May 23, 2019.

15 Rubenstein L, **Amon JJ.** *Global health, human rights, and the law.* The Lancet. 2019 Nov 30;394(10213):1987-8.

OPINION

1 Empowering Women and Realizing Rights. *Toronto Star.* August 11, 2006

2 Why We Need an International AIDS Conference. *Toronto Globe and Mail.* August 15, 2006

3 Curb HIV infection rates in Texas prisons. *Austin American Statesman.* May 10, 2007

4 Diagnosis and Prescriptions. *Foreign Affairs.* May/June 2007

5 The Bush Policy On AIDS. *Huffington Post.* July 26, 2007

6 Saudi Move on HIV/AIDS will make the epidemic worse. *Saudi Debate.* Oct 24, 2007

7 How not to fight HIV/Aids. *The Guardian.* Jan 28, 2008

8 Blaming Foreigners. *The Korea Times.* March 12, 2009

9 Progress against HIV at risk. *Phnom Penh Post.* November 16, 2009

10 HIV Travel Bans: Small Steps, Big Gaps. *Huffington Post.* January 11, 2010

11 Don't Improve Drug Detention: End It. *Huffington Post.* January 15, 2010

12 Torture in health care. *Huffington Post.* January 22, 2010

13 Treatment or punishment? *Bangkok Post.* January 24, 2010

14 Rights abuses threaten HIV risk. *Phnom Penh Post.* January 27, 2010

15 Cambodian drug rehab centers: Abusive, illegal, ineffective. *The Nation (Bangkok).* Jan 27 2010

16 Drug dependence is not a moral issue. *Phnom Penh Post.* January 29, 2010

17 Condoms and Bibles. *The National (PNG)*. February 8, 2010

18 Chronic Pain and Torture. *Huffington Post.* February 23, 2010

19 Invisible Women. *Huffington Post.* March 8, 2010

20 How Not to Protect Children. *Phnom Penh Post.* March 8, 2010

21 Choam Chao needs independent investigation. *Phnom Penh Post.* March 24, 2010

22 March 24 Is World Tuberculosis Day. *Huffington Post.* March 24, 2010
23 Who Will Defend Children in Cambodian Drug Rehab Centres? *The Nation.* March 31, 2010
24 Holiday in Cambodia? *Huffington Post.* April 6, 2010
25 When the Government Sponsors Stigma. *Huffington Post.* April 27, 2010 (with M. McLemore)
26 Zambia's TB-ridden prisons. *The Guardian*. April 27, 2010
27 Chinese Corruption Is Hazardous to Your Health. *Asia Wall Street Journal*. May 13, 2010
28 Why the Vietnamese Don't Want to Go to Rehab. *Foreign Policy.* May 28, 2010
29 Aids and TB are breaking out of prisons. *East African*. June 7, 2010
30 Uganda AIDS Policy: from Exemplary to Ineffective. *The Observer* (Kampala) June 24, 2010
31 When a Problem Comes Along, You Must Whip It. *Huffington Post*. June 26, 2010
32 Action not Rhetoric on HIV and Human Rights. *Huffington Post.* July 2, 2010
33 The Truth About China's Response to HIV/AIDS. *Los Angeles Times*. July 11, 2010
34 HIV Behind Bars. *The Post* (Lusaka). July 11, 2010
35 HIV and Human Rights: Here and Now? *Huffington Post*. July 19, 2010
36 The HIV and TB Prison Crisis in Southern Africa. *Huffington Post*. July 23, 2010
37 Jailing TB patients not remedy for the disease. *The Star* (Nairobi). Sept 17, 2010
38 Rights and Health, Right Now, for Migrants. *Africa Now (Tokyo).* October 2010 (with Kanae Doi)
39 Why Democracies Don't Get Cholera. *Foreign Policy.* October 25, 2010.
40 The Beginning of the End for the War on Drugs? *San Francisco Chronicle.* November 21, 2010
41 Rights Abuses Belie Success in AIDS Fight. *South China Morning Post.* December 1, 2010
42 World AIDS Day: Prevention, Treatment for Prisoners. *Zambia Post.* December 1, 2010
43 Lead poisoning in Nigeria: unprecedented. *Global Post.* December 2, 2010
44 China is hurting its future by not acting on lead. *South China Morning Post.* June 20, 2011
45 Hard life in Ugandan prisons. *The Independent (Uganda).* July 8. 2011
46 'Utterly Irresponsible': Donor Funding in Drug 'Treatment' Centers. *Huff. Post.* Sept 14, 2011
47 National Cashew Day: More Than Nuts. *Global Post.* October 3, 2011
48 A centre for abuse and beating. *The Nation* (Bangkok). October 11, 2011
49 Laos' Murky War on Drugs. *The Diplomat.* October 12, 2011
50 One AIDS march that should end. *Washington Blade.* October 28, 2011
51 Seoul's Broken Promises on HIV Testing. *The Diplomat.* June 29, 2013
52 Drug treatment centres give more abuse than therapy. *Bangkok Post*. December 18, 2013
53 Enlightened drug policies emerge globally, Cambodia remains rigid**.** *Global Post.* Jan 9, 2014
54 Health Under Attack. HRW Dispatch. May 19, 2014 (with Jennifer Pierre)
55 Canada's prostitution bill a step in the wrong direction. *Ottawa Citizen.* June 18, 2014
55 In The HIV Response, Who is 'Hard to Reach'? HRW Dispatch. July 23, 2014
56 Defeating AIDS. HRW Dispatch. June 30, 2015
57 How not to handle Ebola. CNN. September 12, 2014

58 Taking Care of the Caregivers. HRW Dispatch. December 17, 2014

59 Alert in a Time of Cholera. HRW Dispatch. March 26, 2015

60 Stop Using Hospitals as Debtor Prisons. HRW Dispatch. April 14, 2015

61 COP21: The Impact of Climate Change on the World's Marginalized Populations: Turkana County, Kenya. Health and Human Rights Journal Blog. October 27, 2015. (with Katharina Rall)

62 An Important, but Imperfect, Agreement by an Unprecedented Coalition. *US News and World Report.* December 18, 2015

63 Health workers are under attack around the world. Here's how bad it's getting. *Philadelphia Inquirer.* May 28, 2019. (with Jennifer Taylor)

INVITED PRESENTATIONS (SELECT)

1 *Surveillance design and evaluation approach of the Togo Guinea Worm Eradication Program.* III West African Guinea Worm Eradication Conference, Abidjan, Cote d'Ivoire, November 1993.

2 *Knowledge, attitudes and behaviors related to Guinea Worm Eradication, Togo.* IV West African Guinea Worm Eradication Conference, Ouagadougou, Burkina Faso, October 1994.

3 *Synthesis of evaluation results from the AIDSCAP project: 1992-1996.* HIV/STD/AIDS National Forum, Port-au-Prince, Haiti, June 3-5, 1996. Research and Evaluation Panel Chair.

4 *International Trends in HIV-Risk Related Behavior Change.* National Conference on HIV/AIDS, Kingston, Jamaica, November 25-26, 1996.

5 *HIV/AIDS and Adolescents in Ukraine.* Ukrainian-American Medical Society Annual Meeting. Philadelphia, PA, May 2003.

6 *Expanding HIV testing and respecting rights.* International conference on HIV/AIDS and Human Rights. Smolny College. St Petersburg, Russia. October 2005.

7 *HIV in Conflict Settings*. Joint Congressional Human Rights Caucus meeting. Washington DC. March 2006.

8 *Reflections and recollections.* Masters Internationalist - US Peace Corps Symposium. Washington DC. April 2006. (Keynote)

9 *Civil Society Participation in the Response to HIV/AIDS and Accountability.* Presented in panel 1: Breaking the cycle of infection for sustainable AIDS responses. United Nations General Assembly Special Session on HIV/AIDS. New York. June 2006.

10 *HIV testing and human rights.* Public Health Agency of Canada Meeting on HIV Testing. Toronto. August 2006.

11 *Hot Topics in Human Rights*. XVI International AIDS Conference. Toronto. August 2006.

12 *Burma, HIV and Human Rights.* Asia Society. New York. September 2007.

13 *HIV and Youth*. 12th Annual Herbert Rubin and Justice Rose Luttan Rubin International Law Symposium. New York University. New York. October 2007.

14 *HIV testing: human rights considerations*. Funders Network on Population, Reproductive Health and Rights. Annual Meeting, San Antonio, TX. October 2007.

15 *Human Rights and Epidemic Disease: TB control and constraints on rights.* Human Rights Funders Group. Annual Meeting. New York, NY. July 2008.

16 *Promoting Public Health and Human Rights in MDR-TB Care.* International Union against Lung and Tuberculosis Disease. Paris, France. October 2008.

17 *Public Health and Human Rights: Challenges around the World.* New York Academy of Sciences and Johns Hopkins School of Public Health Conference on Public Health and Human Rights. New York, NY. Dec 2008.

18 *Human Rights and Anti-Narcotics Policy.* UN General Assembly, Special Session on Drugs. Vienna, Austria. March 2009.

19 *Rights-based approaches to health.* Interaction Annual Meeting. Arlington, VA. July 2009. (panel moderator)

20 *Health and Human Rights: New orthodoxies and on-going conflicts in repressive states.* Stanford University, Palo Alto, CA. October 2010.

21 *HIV in Asia.* Asia Society. December 1, 2010.

22 *HIV Rights and Wrongs.* GlobeMed National Conference. Northwestern University, Chicago, IL. April 2011. (Keynote)

23 *Human Rights Perspective.* International Workshop on Treatment as Prevention. Vancouver, Canada. May 2011.

24 *Sustaining Environmental, Occupational and Public Health and Community Security: Lead Poisoning in China and Nigeria.* 12th National Conference on Science, Policy and the Environment. Washington, DC. January 2012.

25 *Health and Human Rights in Prisons.* European Infectious Disease meeting. Italy. September 2012. (Keynote)

26 *Measuring Violence against Children and the Effectiveness of Violence Prevention and Reduction Initiatives.* Columbia University. October 2013. (Panel Discussion Moderator)

27 *Political Epidemiology of HIV.* HIV 2014: Science, Community and Policy for Key Vulnerable Populations. New York Academy of Sciences. May 2014.

28 *On the Radar: Police Brutality, Politics & Public Health.* Princeton University. March 2015.

29 *Global Inequalities of Wealth and Health.* Bernstein Institute for Human Rights Annual Conference. New York University School of Law. April 2015.

30 *Environmental and occupational health and human rights.* Health and Human Rights Principles and Pedagogy. Florence, Italy. June 2015.

31 *Interviewing Victims of Human Rights Abuses.* Buzzfeed. New York. June 2015.

32 *Global Health and Governance.* Brookings Institution. May 2016.

33 *Access to pain medicine and human rights.* O'Neill Institute Health Rights Litigation. June 2016

33 *The Morbidity Management and Disability Prevention Project.* Global Alliance for Elimination of Trachoma 2020. Geneva, Switzerland. April 2017.

34 *Human Rights and Phylogenetic Analysis.* Ethics of Phylogenetics. Gates Foundation, UNAIDS, National Institutes for Health. London, UK. May 2017.

35 *Judicialization and access to medicines in Brazil.* O'Neill Institute Health Rights Litigation. Washington DC. June 2016.

36 *Implementing health related SDGs through a human rights perspective.* United Nations Social Forum. Geneva. October 2017.

37 *Indicators, Equity, Rights*. Making the end of AIDS real: Consensus building around what we mean by “epidemic control”. Glion, Switzerland. October 2017.

CONFERENCE PRESENTATIONS

1 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among male STD clinic attendees in Jamaica.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

2 **Amon J**, Bolanos L, Gonzales MT, Zelaya A, Lopez C, Rodriguez J. *Knowledge of, availability, and use of condoms among commercial sex workers in four cities in Honduras.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

3 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among youth aged 12-14 in Jamaica.* XII Int Conf AIDS. 1998; 12:191 (abstract no. 13527).

4 Wedderburn M, **Amon J,** Samiel S, Brathwaite A, Figueroa P. *Behavioral explanations for elevated prevalence of HIV in St. James Parish, Jamaica.* XII Int Conf AIDS. 1998; 12:216-7 (abstract no. 14171).

5 D'Angelo LA, **Amon J,** Lemos ME, Rebeiro MA, Gitchens W, Kotellos K. *Evaluating capacity building of implementing agencies in the AIDSCAP Brazil project*. XII Int Conf AIDS. 1998;12:945 (abstract no. 43503).

6 Saidel T, Mills S, **Amon J,** Rehle T. *Behavioral Surveillance Surveys (BSS) on specific target groups: a valuable complement to standardized general population surveys*. XII Int Conf AIDS. 1998;12:233 (abstract no.14256).

7 Essah KAS, Jackson D, Attafuah JD, **Amon J**, Yeboah KG. *Findings from the 2000 behavioral surveillance survey in Ghana*. XIV International AIDS Conference: Abstract no. C11062

8 Chatterji M, Murray N, Dougherty L, Alkenbrack S, Winfrey B, **Amon J**, Ventimiglia T, Mukaneza A. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* XV Int Conf on AIDS, 2004 (Abstract WePeD6602).

9 Murray NJ, Chatterji M, Dougherty L, Winfrey B, Buek K, **Amon J**, Mulenga Y, Jones A. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* XV Int Conf on AIDS, 2004 (Abstract TuOrD1218).

10 **Amon J**, Devasia R, Xia G, *et al. Molecular Epidemiologic Investigation of Hepatitis A Outbreaks, 2003*. 4th International Conference on Emerging Infectious Disease, Atlanta, GA, March 2004.

11 **Amon J**, Devasia R, Xia G, *et al. Multiple Hepatitis A Outbreaks Associated with Green Onions among Restaurant Patrons – Tennessee, Georgia, and North Carolina, 2003.* 53rd EIS Conference, Atlanta, GA, April 2004. (Winner, Mackel Award)

12 Chatterji M, Murray N, Dougherty L, Ventimiglia T, Mukaneza A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* International Union for the Scientific Study of Population XXV International Population Conference Tours, France, July, 2005.

13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**.. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* International Union for the Scientific Study of Population. International Population Conference France, July, 2005.

14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J.** *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.

16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.

17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J**. *Local and cultural beliefs about HIV transmission fuel childrenīs rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.

18 Cohen J, Epstein H, **Amon J**. *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.

19 Schleifer R, Skala P, Lezhentsev K, **Amon J**. *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.

20 **Amon, J**. *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.

21 Ngonyama L, Lohman D, Clayton M, **Amon J**. *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.

22 Lohman D, Ovchinnikova M, **Amon J**. *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.

23 **Amon J**. *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.

24 Lohman D, Ngonyama L, Clayton M, **Amon J**. *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.

25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province*. XVII International AIDS Conference: Abstract no. THPE1085. August 2008.

26 **Amon J**. Protecting the human rights of people at risk of and affected by TB. 3rd Stop TB Partners Forum, Rio March 2009

27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009

28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.

29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.

30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.

31 **Amon J**. *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.

32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

Biomedical Prevention and Treatment Interventions - The Critical Role of Social Science, Law and Human Rights. International AIDS Society Conference. Cape Town, South Africa. July 2009.

33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.

34 Pearshouse R, **Amon JJ**. *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.

35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J**. *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202

36 Jones L, Akugizibwe P, **Amon J**, et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033

37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J**. *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAF0101

38 McLemore M, Winter M, **Amon J**. *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942

39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J**. *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)

40 Pearshouse R, Cohen JE, **Amon J**. *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203

41 Lohman D, Palat G, Nair S, **Amon J**, Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.

42 Kippenberg J, Thomas L, Lohman D, **Amon J**. *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.

43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.

44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.

45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.

46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.

47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)

48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.

49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.

50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.

51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.

52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)

53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

Universities for Global Health. Washington, DC. March 2013.

54 **Amon J.** *Enhanced HIV testing in the context of human rights*. 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination*. International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.

57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)

58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ,** et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.

59 **Amon J.** Epidemic transition: How will we achieve it while ensuring equity and quality? 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

1 University of North Carolina School of Public Health (March 2006)

2 Duke University School of Public Policy (October 2006)

3 University of Chicago (October 2006)

4 University of Toronto Law School (November 2006)

5 Columbia University Law School (Dec 2006, 2007, 2009)

6 University of Denver School of International Affairs (March 2007)

7 Georgetown University Law School (April 2007)

8 Columbia University School of International and Public Affairs (Feb and Oct 2007)

9 University of Connecticut School of Law (April 2009)

10 New York University (January 2011, November 2014)

11 University of Zurich (September 2011)

12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)

13 Yale University Law School (March 2013)

14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)

15 UCLA Law School (January 2014)

16 Stanford University Law & Medical Schools (January 2014)

17 University of Melbourne, Nossal Institute for Global Health (July 2014)

18 Fordham Law School (October 2014)

19 Northwestern University (November 2014; Nov 2015)

20 Dornsife School of Public Health, Drexel University (February 2018)

21 University of California San Diego (March 2018)

AWARDS

Centers for Disease Control and Prevention, Epidemic Intelligence Service, Mackel Award (Apr 2004)
Department of Health and Human Services, Public Health Service, Unit Commendation (Oct 2004)
Department of Health and Human Services, Secretary's Award for Distinguished Service (Aug 2005)

AD HOC REVIEWER

Journals:

New England Journal of Medicine, Lancet, International Journal of Epidemiology, STI, Global Public Health, Addiction, Hepatology, Health and Human Rights, Bulletin of the World Health Organization, Journal of the International AIDS Society, PLoS One, PLoS Medicine, Journal of the American Public Health Association, Anthropological Quarterly, Drug and Alcohol Dependence, Conflict and Health, BMC Public Health, Harm Reduction Journal, Law & Social Inquiry, Social Science and Medicine, Health and Human Rights Journal, International Journal of Drug Policy.

Grants:

Open Society Foundations, Public Health Program

DECLARATION OF GWENDOLYN STARDA

I, Gwendolyn Starda, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. §1746.

1. My name is Gwendolyn Starda. I make these statements based upon my personal knowledge.
2. I am an attorney with Starda Legal, LLC. I have practiced immigration law for approximately four years.
3. I represent Romel Amaya-Cruz, a 40 year-old El Salvadorian national currently detained in Geauga County Jail ("Geauga") in Chardon, Ohio, where he has remained since January 2020. Mr. Amaya-Cruz has been in continuous detention since December 2018.
4. Mr. Amaya-Cruz came to the United States from El Salvador approximately 25 years ago, at the age of fifteen, without inspection. He was removed to El Salvador in May 2011 after nearly nine years of holding Temporary Protected Status and complying with an Order of Supervision. He re-entered the United States without inspection in early 2013 and has been in the United States ever since.
5. Mr. Amaya-Cruz was detained in December 2018 after the police were summoned in response to his allegedly suspicious behavior in a store, the nature of which is still not clear to this day. Mr. Amaya-Cruz was never charged with any misconduct, but he was nonetheless detained by Immigration and Customs Enforcement ("ICE") when he produced an El Salvadorian identification card to

the responding police officers. Mr. Amaya-Cruz has been in detention ever since his apprehension in December 2018.

6. Mr. Amaya-Cruz succeeded in an appeal of his withholding of removal proceeding, which is now tentatively scheduled for a remanded hearing on April 13, 2020. Because of his withholding proceeding, Mr. Amaya-Cruz is not currently scheduled for deportation.

7. Mr. Amaya-Cruz is HIV-positive and suffers from numerous ensuing complications, such as brain lesions (bleeding on the brain), toxoplasmosis (a parasitic infection, often found in immunocompromised patients), and toxoplasmic encephalitis (swelling of the brain caused by toxoplasma infection). Mr. Amaya-Cruz also suffers from chronic headaches and eczema. Because of his medical conditions, he believes that he is at a high risk of serious complications stemming from COVID-19.

    a. Although Mr. Amaya-Cruz currently takes several antiretroviral medications to manage his HIV, I understand that he has had heightened levels of HIV present in his body since entering Geauga. In that time, he has been unable to see the physician who normally managed his HIV medication regimen. And notwithstanding his HIV-positive status and various medical conditions, he only sees the detention facility's chronic care provider quarterly.

    b. Prior to detention, his doctor also monitored his toxoplasma infection, which requires additional medication if the infection worsens. His toxoplasma infection is not currently being monitored or treated with

medication. Prior to detention, Mr. Amaya-Cruz also received regular MRIs to monitor his brain lesions and toxoplasmic encephalitis. Mr. Amaya-Cruz has not had one MRI in the more than 18 months he has spent in detention. Mr. Amaya-Cruz continues to complain of headaches and neck pain, which I understand can be indications that his toxoplasma infection is worsening. At present, Mr. Amaya-Cruz is given only Tylenol for the pain, which he states has little effect.

8. I last spoke with Mr. Amaya-Cruz on April 10, 2020. Geauga has prohibited attorney-client visits, so I can only communicate with my client through telephone or video conference calls.

9. Through my representation of Mr. Amaya-Cruz, I have learned the following about conditions in Geauga:

   a. Detainees are housed in pods of up to 60 people. At present, approximately 20-30 detainees are in Mr. Amaya-Cruz's pod. There are no windows that open to the outside or allow fresh air into the pod. The beds in the pod are approximately two feet apart. As a result, it is impossible to maintain social distance of six feet of distance from other people at all times.

   b. In the past two weeks, Mr. Amaya-Cruz estimated that he has shared his pod with approximately 60 different people. Multiple people have been transferred in and out of the pod in the last two weeks. Most recently, several individuals were transferred into the pod approximately three days ago. Some people are coughing, but after they see a nurse they are

returned to the general population. The staff said that they would move sick people to another location, but Mr. Amaya-Cruz has not seen that happen.

c. Detainees do not have access to tests for COVID-19, and Mr. Amaya-Cruz does not know if guards or staff have such access. Mr. Amaya-Cruz knows of one detainee who requested a test and was denied. For a week or two, the nurse took everyone's temperature daily, but that stopped between two and three weeks ago.

d. Detainees eat in the same room at the same time. They eat at small round tables, usually seating four people. All the round tables are less than six feet apart. Mr. Amaya-Cruz has not seen staff sanitizing the chairs or tables before meals.

e. Detainees do not have access to free soap. Any soap must be bought from the commissary. There are no paper towels or toilet paper available by the sinks. The facility usually provides one roll of toilet paper every two days for personal use, including drying one's hands. Sometimes, guards will check the detainees' personal belongings and if detainees have more than one toilet paper roll, will take away the additional rolls. Mr. Amaya-Cruz told me that he requested extra because he suffers from diarrhea as a result of his medical conditions and the associated medication regime, but he has not been given any.

f. One day a week, detainees are tasked with cleaning the toilets but are not given gloves. Mr. Amaya-Cruz also told me that there are many flies and mosquitoes in the facility.

g. Staff began to wear masks two or three days ago, but they do not wear them all the time. Mr. Amaya-Cruz has seen staff wearing gloves

10. No one in Geauga is able to practice social distancing. As stated above, the detainees live, sleep, and eat in close quarters and it is impossible to maintain a social distance of six feet from other people at all times.

11. From his initial entry to the United States in 1996 until his detention in 2018, Mr. Amaya-Cruz's criminal history contains only misdemeanor convictions, the most recent of which occurred in 2010. His misdemeanors are for speeding (once in 2006, twice in 2007, and once in 2008), driving without a license (2006, 2008), and operating a vehicle while intoxicated (2008, 2010). While detained, he was also prosecuted and found guilty of illegal reentry to the United States.

12. If released, Mr. Amaya-Cruz will stay with his U.S. citizen sister, who lives in the Cleveland area. While staying with his sister, Mr. Amaya-Cruz would maintain a safe distance from others and/or quarantine as necessary. He will also be able to get medical treatment for his conditions from his former physician, who is an infectious disease specialist at the Cleveland Clinic.

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

Executed on the 10th day of April 2020, in Hinckley, Medina County, Ohio.

/s/ Gwendolyn Starda
Gwendolyn Starda

Starda Legal, LLC
148 E Liberty Avenue
Suite 224
Wooster, Ohio 44691

DECLARATION OF MAUREEN DEVITO

I, Maureen DeVito, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. §1746.

1. My name is Maureen DeVito. I make these statements based upon my personal knowledge.
2. I am an attorney with the Catholic Charities, Diocese of Cleveland, Ohio. I have practiced immigration law for approximately four years.
3. I represent Jonas Nsongi Mbonga, a 30 year-old national of the Democratic Republic of Congo ("DRC"), who has been detained in the Geauga County Jail ("Geauga") in Chardon, Ohio since February 21, 2020.
4. Mr. Nsongi Mbonga came to the United States seeking asylum on July 18, 2018. Mr. Nsongi Mbonga's asylum claim stems in part from being detained and tortured in the DRC by agents of his political opponents. In 2014, DRC government agents beat Mr. Nsongi Mbonga with a baton until he lost consciousness, causing multiple concussions and a traumatic, lasting brain injury.
5. Although U.S. Citizenship and Immigration Services ("USCIS") found that Mr. Nsongi Mbonga had a credible fear of returning to DRC, an immigration judge nonetheless denied his asylum claim. Mr. Nsongi Mbonga's appeal of his asylum denial is currently pending before the Board of Immigration Appeals.
6. Mr. Nsongi Mbonga is worried about exposure to COVID-19 due to a number of serious, pre-existing medical issues.
    a. Mr. Nsongi Mbonga tested positive for latent tuberculosis in May 2019. Latent tuberculosis is a respiratory infection that affects the lungs. Certain

illnesses, such as a flu, trigger active tuberculosis. Doctors at the Cleveland Clinic prescribed him medicine, but he did not receive all the doses prescribed while in detention.

b. Mr. Nsongi Mbonga also experiences chronic headaches, which last about one hour at a time and occur up to three times a day. His headaches induce nausea, vertigo and changes in his vision. Mr. Nsongi Mbonga has only been given Tylenol while in ICE detention, which has not been effective in treating this condition.

c. Mr. Nsongi Mbonga suffers from severe abdominal pain that has led to multiple hospitalizations. He has been diagnosed with, among other things, gastroenteritis and amebiasia, an inflammation of the lining of the intestines caused by an intestinal virus or parasite. Prior to being moved to Geauga, he was prescribed medication, but received less than half of the recommended doses. In Geauga, he has suffered acute abdominal pain, which has led to significant weight loss. This severe pain has also disrupted his sleep.

7. Mr. Nsongi Mbonga has no criminal record. Correctional facility staff have described him as a model inmate.

8. I last spoke with Mr. Nsongi Mbonga on April 10, 2020. Through the course of my representation of Mr. Nsongi Mbonga, I have also learned the following about conditions in Geauga:

a. Detainees are housed in a dormitory divided only by concrete half-walls, approximately three feet tall, that can house up to 60 people. At present,

Mr. Nsongi Mbonga shares the room with approximately 30 detainees. The beds are about three feet apart. As a result, it is impossible to practice adequate social distancing.

b. There are no windows in the dormitory and there is no natural light. The only ventilation comes from flaps that are high up on the walls.

c. All male detainees eat together at the same time. The tables are approximately three feet apart. Four detainees sit at each table. Mr. Nsongi Mbonga has not seen staff sanitizing the chairs or tables before meals. Guards wear gloves and began wearing mask earlier this week. The inmates have not been given face masks or any other personal protective equipment. Inmates are only provided gloves if they work in the kitchen.

d. Jail staff has not ever provided detainees with information about COVID-19 or its developments.

e. Detainees do not have access to tests for COVID-19. At least one detainee, an elderly man, was removed briefly from the general population after seeming ill, but was brought back to the communal room shortly thereafter, still visibly sick.

f. Detainees do not have access to free soap or hand sanitizer. Any soap or shampoo must be bought from the commissary. Only four individuals in Mr. Nsongi Mbonga's room have money in their account to buy soap.

9. If released, Mr. Nsongi Mbonga will stay at the home of attorney Brian Hoffman in Wooster, OH. While staying with Mr. Hoffman, Mr. Nsongi Mbonga would

maintain a safe distance from others and/or quarantine as necessary. He would also have access to treatment for his medical conditions.

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

Executed on the 10th day of April 2020, in Cleveland, Cuyahoga County, Ohio.

/s/ Maureen DeVito

Maureen DeVito, Esq.
Immigration Staff Attorney, Mitigation and Refugee Services
Catholic Charities, Diocese of Cleveland
7800 Detroit Avenue
Cleveland, OH 44102

DECLARATION OF MARGARITA S. KRNCEVIC, ESQ.

I, Margarita S. Krncevic, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. §1746.

1. My name is Margarita S. Krncevic. I am Of Counsel with the law firm of Benesch, Friedlander, Coplan & Aronoff LLP in Cleveland, Ohio. In this capacity, I have represented Elvira Pascalenco in her immigration proceedings since approximately February 2020.
2. I make these statements based upon my personal knowledge after having had conversations with my client, Elvira Pascalenco, and her U.S. citizen son, Igor Matsenko.
3. Ms. Pascalenco is a fifty-two-year old national of Moldova who has been in civil immigration detention at Geauga County Jail ("Geauga") in Chardon, Ohio, since approximately January 23, 2020.
4. Ms. Pascalenco entered the United States in June 2007 as a conditional Lawful Permanent Resident ("LPR"). Ms. Pascalenco has remained in the United States since her entry in 2007, and on or about July 10, 2009, Ms. Pascalenco had the conditions on her LPR status removed.
5. On or around January 23, 2020, Immigration and Customs Enforcement ("ICE") arrested Ms. Pascalenco while she attended a routine interview in support of her application for naturalization at the Cleveland, Ohio office of the United States Citizenship and Immigration Services ("USCIS"). As I detail below, Ms. Pascalenco was arrested at this time based on a disputed 2008 *in absentia* conviction for trafficking marijuana in Russia.

6. Ms. Pascalenco has suffered and continues to suffer from a number of serious medical conditions:

    a. Ms. Pascalenco suffers from asthma, and has been instructed by her physician to take inhaler treatments every four hours, every single day. She is also supposed to take Singulair daily to control her asthma.

    b. Further, Ms. Pascalenco suffers from inflammation and a bone spur in her left foot, swelling and related issues with her Achilles tendons, recurrent major depressive disorder, migraines, chronic bilateral low back pain, high cholesterol, osteoporosis, and generalized anxiety disorder.

    c. Additionally, Ms. Pascalenco is allergic to various medications, such as Atorvastatin and Paroxetine Hcl. Ms. Pascalenco has been prescribed twenty medications by her primary care physician from May 2017 to January 30, 2020, to treat her various medical conditions.

    d. Ms. Pascalenco's family members are in possession of her medications and inhaler at their home. On at least one occasion, Mr. Matsenko has requested to drop off Ms. Pascalenco's prescription inhaler at the detention facility. According to Mr. Matsenko, ICE refused to accept the inhaler because the package had already been opened. Ms. Pascalenco has heard from other detainees and a facility nurse that the facility has an inhaler that detainees must share. Ms. Pascalenco heard from an asthmatic female detainee who actually used the facility's inhaler that the inhaler was not disinfected before use.

e. According to Mr. Matsenko, the medical professionals at Geauga have told Ms. Pascalenco that they do not have her cholesterol medication, and that she must arrange to order this medication on her own. Ms. Pascalenco's cholesterol is very high and failure to control her cholesterol increases her chances of dying from a heart attack.

f. Recently, Ms. Pascalenco has reported feeling panicked, depressed, and generally in pain. In general, Ms. Pascalenco has been housed in a single cell since being detained on or around January 24, 2020. However, other detainees have been housed with her in her cell at various points in time. Ms. Pascalenco's cell is about two meters wide and four meters long, has two metal beds, a toilet and sink, two lockers, and a metal table with a metal chair.

g. In early March 2020, Ms. Pascalenco shared her cell with two other detainees, one of whom was a woman who was ill with a fever who was coughing and spitting. Ms. Pascalenco shared her cell with this sick detainee for approximately seven to ten days. This woman was eventually released from detention.

h. In mid-March 2020, Ms. Pascalenco shared her cell with one other woman for four days, before being housed alone once again.

i. Ms. Pascalenco has observed that the facility's showers are dirty and covered in mold, and are shared by everyone. The detainees have tried to clean the showers themselves, but they do not have sufficient cleaning supplies.

j. Outside of her cell, Ms. Pascalenco cannot maintain six feet of distance from other detainees when taking meals or receiving medication. Ms. Pascalenco reports that meals are still taken in a communal setting, with multiple detainees sharing tables and sitting close together. People who serve the meals are passing them to detainees through a doorway. However, the people delivering the meals do not always wear gloves. As for receiving medication, detainees stand in a single-file line close together.

k. Geauga does not provide Ms. Pascalenco with free soap or sanitizers; she must purchase these items herself.

l. Ms. Pascalenco has observed that only some corrections officers wear masks, and even those who do wear masks only started doing so on or around April 7, 2020. She has further observed that some corrections officers wear gloves, although she has seen some officers place medications into their ungloved hands to hand them to detainees. Ms. Pascalenco has not seen corrections officers replace masks or gloves between uses. As recently as April 10, 2020, Ms. Pascalenco observed some corrections officers not wearing masks and gloves.

m. Ms. Pascalenco does not know if Geauga provides COVID-19 testing, or if anyone at Geauga has tested positive.

n. Ms. Pascalenco reports that there is a narrow, opaque window in her room that does not open. She can tell if it is day or night, but there is no incoming natural light. As for recreation, detainees are not allowed to go

outside of the facility. Instead, they are permitted to go to a library that has no windows or doors leading outside.

o. About two weeks ago, Ms. Pascalenco observed corrections officers checking detainees' temperatures with an in-ear thermometer. The corrections officers used the same thermometer on multiple detainees, wiping the thermometer with a towel before moving on to the next detainee. Temperature checks lasted for two days, and then stopped. The corrections officers told detainees that if they had a fever, they should contact the officers.

p. After two days of temperature checks, two people who were sick were released from detention. Ms. Pascalenco observed a corrections officer come to her cell block, where the sick detainees were also housed. The corrections officer told the ill detainees to gather their belongings and leave the cell block. Ms. Pascalenco does not know if these individuals went home or were moved to a different location.

q. According to Ms. Pascalenco, one of the released detainees was very ill while detained and "contaminated three or four people." Ms. Pascalenco reports that the woman was treated at the facility. However, corrections officers have told detainees that if they want to receive medical treatment, they need to submit a "request" and that it takes one day to get a response. Ms. Pascalenco claims that there was another female detainee who had nausea and diarrhea, but did not receive treatment until she blacked out.

r. Detainees have been told by corrections officers and a nurse that if someone contracts COVID-19, the detention center will go on lockdown. Ms. Pascalenco observed a medical professional at the facility, along with a corrections officer, tell detainees, "Don't expect to get released because of COVID-19."

7. Given the nature of COVID-19, Ms. Pascalenco's pre-existing medical conditions, and the utter lack of social distancing or comprehensive sanitization measures at Geauga, Ms. Pascalenco is at a high risk of infection for COVID-19 while in detention. Moreover, ICE has inexplicably refused to allow Ms. Pascalenco's son to provide her with her prescribed inhaler from home. Accordingly, Ms. Pascalenco is especially vulnerable to severe health complications from COVID-19, a respiratory virus.

8. Ms. Pascalenco entered removal proceedings based upon an *in absentia* conviction for trafficking marijuana issued against her in Russia in 2008. This *in absentia* conviction was based on allegations that, in 2004, Ms. Pascalenco sold marijuana to an individual who was working for Russian drug enforcement agents. Ms. Pascalenco has stated that she was kidnapped, blindfolded, beaten, and threatened with death in an apartment by three men in plainclothes. Ms. Pascalenco later learned that these men were undercover drug enforcement agents. While at the apartment, Ms. Pascalenco was forced to sign documents that she was not permitted to read under threat of death. She now believes that these documents were a confession.

9. Throughout this entire ordeal, Ms. Pascalenco was never provided with any legal counsel, handcuffed, arraigned before a judge, or provided any legal rights or due process. She was subsequently dropped off in a police station, where she was released without having to post any bond. Documents from Russia show that she was released because there was insufficient evidence to remand her into custody. Ms. Pascalenco's prosecution was executed by Valery Samoilov, a former prosecutor in Moscow who was later arrested and prosecuted for running a criminal enterprise around the same period as her *in absentia* conviction.
10. With my assistance, Ms. Pascalenco is contesting her charges of removability, which are based on the 2008 Russian *in absentia* conviction, before the Cleveland Immigration Court. Ms. Pascalenco attended a partial contested removal hearing by telephone on April 7, 2020, which was then continued to May 6, 2020. The dubious nature of Ms. Pascalenco's *in absentia* conviction from Russia leads me to believe we will prevail in contesting the charges of removability against her.
11. Ms. Pascalenco has resided lawfully in the United States since 2007. She has never committed a crime in the United States or in her home country of Moldova, and denies that she ever trafficked marijuana in Russia. She has the ongoing support of her U.S. citizen son, her U.S. citizen twin sister, and her U.S. citizen mother. Prior to detention, Ms. Pascalenco helped to provide daily care for her mother, who lives on her own despite partial paralysis. Ms. Pascalenco looks forward to continuing to care for her mother, should she be released, consistent with her safety and good hygiene.

12. If she is released, Ms. Pascalenco will return to the home she shared with her son, Mr. Matsenko, in Mayfield Heights, Ohio. Mr. Matsenko is a student, and prior to detention Ms. Pascalenco assisted him with household and educational expenses. Ms. Pascalenco, if released, will again be under the care of her physicians to address her myriad medical issues. Finally, Ms. Pascalenco will be able to maintain safe distances from others and can quarantine as necessary.

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

Executed on the 10th day of April 2020, in Cleveland, Ohio.

/s/ Margarita S. Krncevic

Margarita S. Krncevic, Esq.
Benesch, Friedlander, Coplan & Aronoff LLP
200 Public Square, Suite 2300
Cleveland, Ohio 44114

DECLARATION OF ATTORNEY BRIAN HOFFMAN

I, Brian J. Hoffman, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Brian Hoffman and I am an attorney with offices in Cleveland, Ohio, and Wayne County, Ohio. These statements are based upon my personal knowledge after communications with my clients.
2. I represent Hector Manuel Reyes Cruz in his immigration proceedings. Mr. Reyes Cruz is currently detained in the Seneca County Jail ("Seneca") in Tiffin, Ohio. I also represent other individuals currently detained at Seneca in connection with immigration proceedings.
3. Mr. Reyes Cruz was born in Honduras and is 42 years old.
4. Mr. Reyes Cruz entered the United States on March 28, 2019 to flee from a Transnational Criminal Organization in Honduras. This was his first and only entry into the United States. He entered without inspection, and the United States Immigration and Customs Enforcement agency ("ICE") immediately took him into custody and placed him in detention in Youngstown, Ohio. ICE transferred Mr. Reyes Cruz to Seneca on or around January 2020, where he remains.
5. Prior to March 12, 2020, I regularly visited Mr. Reyes Cruz at Seneca. Currently, I am unable to visit Seneca to speak to Mr. Reyes Cruz in person due to coronavirus-related concerns. Our method of communication has thus been limited to emails and telephone calls.

6. Through my communications with my clients at Seneca, including Mr. Reyes Cruz, I have learned the following about the general conditions at Seneca:
    a. All of the ICE detainees at the facility, currently 35, share the jail's 40-bed dormitory-style housing unit. Detainees estimate the beds are only three feet (one meter) apart and it is impossible to keep adequate distance from other detainees. When a detainee is sick, that illness can and often does spread to other detainees.
    b. Detainees are only given two small bottles of soap per week for both bathing and cleaning, which is insufficient. As a result, they must purchase their own from the commissary. Detainees have had to use their own personal cleaning products—including those purchased from the commissary—to clean the common areas such as bathrooms. Detainees report that usable cleaning products are regularly discarded by jail staff during searches of the sleeping areas.
    c. There are insufficient bathroom facilities for the number of detainees in the jail, and the bathrooms are dirty and unsanitary. I have never observed any exterior-facing windows or ventilation during the times I've accessed the facility, and clients have told me there is no outdoor recreation.
7. No detainee has been tested for COVID-19 despite certain detainees exhibiting signs of COVID-19. Requests for medical treatment are often ignored altogether. Corrections officers at Seneca have not been wearing protective gloves or masks. Masks have not been made available to detainees, even those who are symptomatic for COVID-19.
8. Mr. Reyes Cruz has hypertension, or high blood pressure. He also has had a persistent cough for the past two months for which he has been unable to get treatment despite his repeated attempts to secure care. He informed me that he takes five pills every day:

ibuprofen, the antidepressant Remeron, and the antihistamine hydroxyzine. Remeron and hydroxyzine were prescribed by his mental health provider to treat his anxiety and depression. Without them, he can't sleep. He also has severely painful toothaches that continue to be left untreated despite his requests.

9. Mr. Reyes Cruz fears he is in very bad health generally, for which he cannot receive treatment. He also reports that hygiene is very poor at the Seneca facility.
10. Mr. Reyes Cruz has no criminal history.
11. I have worked extensively with community groups and volunteers around Ohio for nearly two years, and have successfully arranged transportation for dozens of formerly detained men to their families around the country. If he is released, I will ensure that Mr. Reyes Cruz is picked up at the jail, that arrangements are made to transport him to his friends in Charlotte, North Carolina, and that he is instructed on the nature and importance of self-quarantine.

Pursuant to 28 U.S.C. § 1746, I certify under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on:

/s/ Brian J. Hoffman 4/10/2020

Brian J. Hoffman, Esq., Executive Director
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DECLARATION OF MY KHANH NGO, ESQ.
IN SUPPORT OF PETITIONER-PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

I, My Khanh Ngo, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. §1746.

1. My name is My Khanh Ngo. I am over the age of 18 and am competent to make this declaration.

2. I am a Staff Attorney with the American Civil Liberties Union Foundation, Immigrants' Rights Project, and am one of the counsel of record for Petitioner-Plaintiffs.

3. I certify that the attached exhibits are true and correct copies of the following:

Exhibit	Document
A	Coronavirus disease 2019 (COVID-19) Situation Report – 80, World Health Organization (Apr. 9, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200409-sitrep-80-covid-19.pdf?sfvrsn=1b685d64_2.
B	U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases (last updated Apr. 10, 2020), https://www.ice.gov/coronavirus.
C	Ken Klippenstein, *Exclusive: ICE Detainees Are Being Quarantined*, The Nation (Mar. 24, 2020), https://www.thenation.com/article/society/corona-covid-immigration-detention/.
D	Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al. (Mar. 19, 2020), https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf.
E	Yeganeh Torbati et al., *In a 10-Day Span, ICE Flew This Detainee Across the Country – Nine Times*, Big Easy Magazine (Mar. 30, 2020), https://www.bigeasymagazine.com/2020/03/30/in-a-10-day-span-ice-flew-this-detainee-across-the-country-nine-times/.
F	Noah Lanard, *A Haitian Asylum-Seeker Did Everything Right. ICE Sent Him to a Windowless Jail Cell*, Mother Jones (Dec. 7, 2018), https://www.motherjones.com/politics/2018/12/a-haitian-asylum-seeker-did-everything-right-ice-sent-him-to-a-windowless-jail-cell/.

G Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders (Mar. 21, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/News/covid-19/Letter-from-BOC-re-NYC-Jails-and-COVID-19-2020-03-21.pdf.

H Linh Ta, *Iowa's Prisons Will Accelerate Release of Approved Inmates To Mitigate COVID-19*, Times Republican (Mar. 23, 2020), https://www.timesrepublican.com/news/todays-news/2020/03/iowas-prisons-will-accelerate-release-of-approved-inmates-to-mitigate-covid-19/.

I *Release Ohio Jail Inmates Vulnerable to Coronavirus, Chief Justice Urges*, WLWT5 (Mar. 19, 2020), https://www.wlwt.com/article/release-ohio-jail-inmates-vulnerable-to-coronavirus-chief-justice-urges/31788560.

J Adam Ferrise, *Coronavirus Got 900 Inmates Out of Cuyahoga County's Troubled Jail When Inmate Deaths Didn't. Some Say the Changes Should Stick* (Apr. 1, 2020), https://www.cleveland.com/court-justice/2020/04/coronavirus-got-900-inmates-out-of-cuyahoga-countys-troubled-jail-when-inmate-deaths-didnt-some-say-the-changes-should-stick.html.

K John Sandweg, *I Used to Run ICE. We Need to Release the Nonviolent Detainees*, The Atlantic (Mar. 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536/.

L Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff (Mar. 16, 2020), https://www.sccourts.org/whatsnew/displayWhatsNew.cfm?indexId=2461.

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

Executed on this 10th day of April, 2020, in Oakland, California.

/s/ My Khanh Ngo

My Khanh Ngo*
American Civil Liberties Union Foundation Immigrants' Rights Project
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Exhibit A

April 9, 2020 Coronavirus disease 2019 (COVID-19) Situation Report – 80, World Health Organization

Coronavirus disease 2019 (COVID-19)
Situation Report – 80

World Health Organization

Data as received by WHO from national authorities by 10:00 CET, 9 April 2020

HIGHLIGHTS

- No new country/territory/area reported cases of COVID-19 in the past 24 hours.
- The daily situation report will now report the COVID-19 transmission scenario for each country using the definitions published in the updated global surveillance guidance published on 20 March (here). Transmission scenarios are self-reported by Member States to WHO. The determination of transmission scenario is still pending for some Member States. The transmission scenarios are: no confirmed cases, sporadic cases, clusters of cases, and community transmission. For definitions and more details, see the footnote under Table 1 below.
- As millions of Christians, Jews and Muslims celebrate Easter, Passover and Ramadan, WHO has released guidance for religious leaders and faith-based communities in the context of COVID-19. This is available here. For more on this topic, see the 'Subject in Focus' below.
- Today marks 100 days since WHO was notified of the first cases of "pneumonia with unknown cause" in China. In yesterday's media briefing, Director-General Dr Tedros recalled the work that WHO and its partners have been doing over this period and the continuing efforts to stop the pandemic in five key areas. Find more details here.

SITUATION IN NUMBERS
total (new) cases in last 24 hours

Globally
1 436 198 confirmed (82 837)
85 522 deaths (6287)

European Region
759 661 confirmed (39 442)
61 516 deaths (3877)

Region of the Americas
454 710 confirmed (37 294)
14 775 deaths (2178)

Western Pacific Region
115 852 confirmed (1185)
3944 deaths (22)

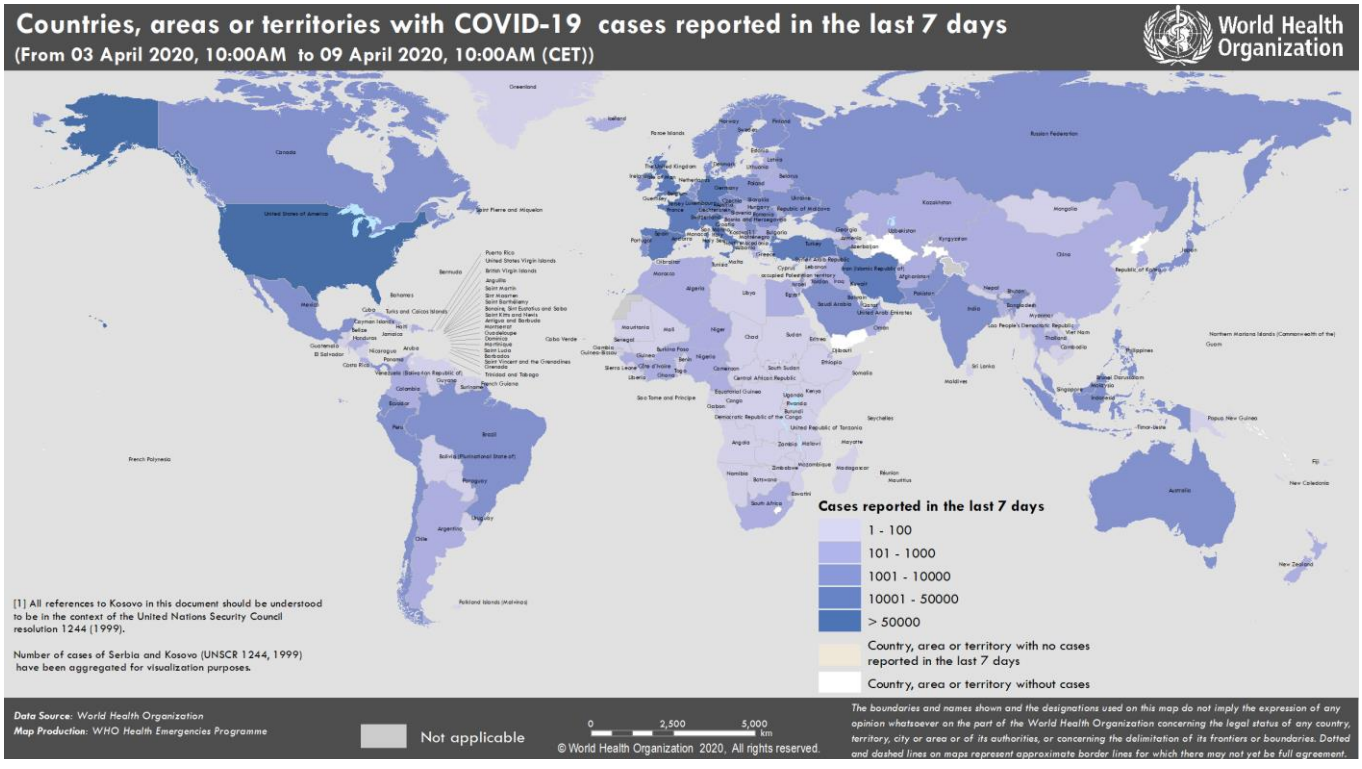
Eastern Mediterranean Region
85 350 confirmed (3357)
4459 deaths (145)

South-East Asia Region
11 576 confirmed (869)
468 deaths (42)

African Region
8337 confirmed (690)
349 deaths (23)

WHO RISK ASSESSMENT
Global Level Very High

Figure 1. Countries, territories or areas with reported confirmed cases of COVID-19, 9 April 2020



SUBJECT IN FOCUS: Having faith during COVID-19

A sad reality of the COVID-19 pandemic is that many people have been infected in settings where they turn to for comfort at these difficult times. There have been outbreaks of COVID-19 among religious communities due to certain religious practices. To help stop transmission in communities while allowing people options to worship, WHO's Information Network for Epidemics (EPI-WIN) brings together members of diverse faith-based communities in virtual meetings and discussions. The EPI-WIN team and faith experts discuss the critical role of religious leaders and faith-based communities in saving lives and reducing illness during the COVID-19 pandemic and beyond.

Faith-based communities play a substantial role in supporting local health systems; advocating for the rights of vulnerable populations; providing support and comfort to communities; and being a trusted source of information. They are often integrated into broader communities through the services they provide, and in doing so they reach the most vulnerable groups with assistance and health information.

The EPI-WIN team and the faith community have co-developed practical guidance and recommendations, available here, to support the special role of religious leaders, faith-based organizations, and faith-based communities in COVID-19 education, preparedness, and response. This includes:

- Sharing evidence-based information about COVID-19, preparedness, and response
- Avoiding large group gatherings and conducting rituals and faith-related activities remotely/virtually, as required and whenever possible
- Ensuring that any decision to convene group gatherings for worship, education, or social meetings is based on a sound risk assessment and in line with guidance from national and local authorities
- Ensuring safe faith-based gatherings, ceremonies, and rituals when they do occur
- Strengthening mental and spiritual health, well-being and resilience, through individual contact (while observing appropriate physical distancing) and through social and other communications media
- Ensuring a human-rights-based approach to advocacy, messaging and service delivery
- Addressing stigma, violence, and the incitement of hate
- Promoting ecumenical and interfaith collaboration, and peaceful coexistence during the COVID-19 pandemic
- Ensuring that accurate information is shared with communities; and misinformation in addressed.

EPI-WIN have also developed a mass gatherings risk assessment tool available here, and a decision tree available here.

SURVEILLANCE

Table 1. Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths. Data as of 9 April 2020[*]

Reporting Country/ Territory/Area[†]	Total confirmed [‡] cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[§]	Days since last reported case
Western Pacific Region						
China	83249	92	3344	2	Cluster of cases	0
Republic of Korea	10423	39	204	4	Cluster of cases	0
Australia	6052	96	50	5	Cluster of cases	0
Japan	4768	511	85	4	Cluster of cases	0
Malaysia	4119	156	65	2	Cluster of cases	0
Philippines	3870	106	182	5	Cluster of cases	0
Singapore	1623	142	6	0	Cluster of cases	0
New Zealand	992	23	1	0	Sporadic Cases	0
Viet Nam	251	2	0	0	Cluster of cases	0
Brunei Darussalam	135	0	1	0	Sporadic Cases	4
Cambodia	117	2	0	0	Sporadic Cases	0
Mongolia	16	1	0	0	Sporadic Cases	0
Fiji	15	0	0	0	Sporadic Cases	1
Lao People's Democratic Republic	15	3	0	0	Sporadic Cases	0
Papua New Guinea	2	1	0	0	Sporadic Cases	0
Territories[**]						
Guam	125	4	4	0	Cluster of cases	0
French Polynesia	51	4	0	0	Sporadic Cases	0
New Caledonia	18	0	0	0	Sporadic Cases	6
Northern Mariana Islands (Commonwealth of the)	11	3	2	0	Pending	0
European Region						
Spain	146690	6180	14555	757	Pending	0
Italy	139422	3836	17669	540	Pending	0
Germany	108202	4974	2107	246	Pending	0
France	81095	3869	10853	540	Pending	0
The United Kingdom	60737	5491	7097	938	Pending	0
Turkey	38226	4117	812	87	Community Transmission	0
Belgium	23403	1209	2240	205	Pending	0
Switzerland	22710	546	705	64	Community Transmission	0
Netherlands	20549	969	2248	147	Pending	0
Portugal	13141	699	380	35	Pending	0
Austria	12969	329	273	30	Pending	0
Russian Federation	10131	2634	76	18	Cluster of cases	0
Israel	9404	0	71	0	Pending	1
Sweden	8419	726	687	96	Pending	0

Ireland	6224	515	235	25	Pending	0
Norway	6010	147	80	11	Pending	0
Denmark	5402	331	218	15	Pending	0
Czechia	5312	295	99	11	Pending	0
Poland	5205	357	159	30	Pending	0
Romania	4761	344	209	27	Pending	0
Luxembourg	3034	64	46	2	Pending	0
Serbia	2666	219	65	4	Pending	0
Finland	2487	179	40	6	Pending	0
Ukraine	1892	224	57	5	Cluster of cases	0
Greece	1884	52	83	2	Pending	0
Iceland	1616	30	6	0	Pending	0
Croatia	1343	61	19	1	Pending	0
Estonia	1185	36	24	3	Pending	0
Republic of Moldova	1174	118	28	6	Pending	0
Slovenia	1091	36	40	4	Pending	0
Belarus	1066	205	13	0	Cluster of cases	0
Hungary	980	85	66	8	Pending	0
Armenia	921	44	10	2	Cluster of cases	0
Lithuania	912	32	15	0	Pending	0
Azerbaijan	822	105	8	0	Cluster of cases	0
Bosnia and Herzegovina	816	35	35	3	Community Transmission	0
Kazakhstan	727	18	7	1	Pending	0
Slovakia	682	84	2	0	Pending	0
North Macedonia	617	18	30	3	Cluster of cases	0
Bulgaria	593	16	24	1	Pending	0
Latvia	577	29	2	0	Pending	0
Andorra	566	15	24	2	Community Transmission	0
Uzbekistan	555	21	3	0	Cluster of cases	0
Cyprus	526	32	14	0	Pending	0
Albania	409	9	22	0	Cluster of cases	0
San Marino	308	29	34	0	Community Transmission	0
Malta	299	6	1	1	Pending	0
Kyrgyzstan	280	10	4	0	Pending	0
Montenegro	248	0	2	0	Cluster of cases	1
Georgia	214	6	3	0	Cluster of cases	0
Liechtenstein	79	1	1	0	Pending	0
Monaco	54	14	0	0	Sporadic Cases	0
Holy See	8	1	0	0	Sporadic Cases	0
Territories**						
Kosovo[1]	224	40	6	1	Community Transmission	0
Faroe Islands	184	0	0	0	Pending	1
Jersey	170	0	3	0	Pending	1
Guernsey	166	0	4	0	Pending	1
Isle of Man	150	0	1	0	Pending	1
Gibraltar	113	0	1	0	Pending	1

Greenland	11	0	0	0	Pending	3
South-East Asia Region						
India	5734	540	166	17	Community Transmission	0
Indonesia	2956	218	240	19	Community Transmission	0
Thailand	2423	54	32	2	Community Transmission	0
Bangladesh	218	54	20	3	Community Transmission	0
Sri Lanka	189	3	7	1	Cluster of cases	0
Myanmar	22	0	3	0	Sporadic Cases	1
Maldives	19	0	0	0	Cluster of cases	6
Nepal	9	0	0	0	Cluster of cases	4
Bhutan	5	0	0	0	Sporadic Cases	6
Timor-Leste	1	0	0	0	Sporadic Cases	19
Eastern Mediterranean Region						
Iran (Islamic Republic of)	64586	1997	3993	121	Pending	0
Pakistan	4322	250	63	5	Cluster of cases	0
Saudi Arabia	2932	137	41	0	Cluster of cases	0
United Arab Emirates	2659	300	12	0	Pending	0
Qatar	2210	153	6	0	Pending	0
Egypt	1560	110	103	9	Cluster of cases	0
Morocco	1275	91	93	3	Cluster of cases	0
Iraq	1202	80	69	4	Cluster of cases	0
Kuwait	855	112	1	0	Cluster of cases	0
Bahrain	823	12	5	0	Cluster of cases	0
Tunisia	628	5	24	1	Community Transmission	0
Lebanon	575	27	19	0	Cluster of cases	0
Oman	457	38	2	0	Cluster of cases	0
Afghanistan	444	21	15	1	Cluster of cases	0
Jordan	358	5	6	0	Cluster of cases	0
Djibouti	135	14	0	0	Cluster of cases	0
Libya	21	1	1	0	Cluster of cases	0
Syrian Arab Republic	19	0	2	0	Community Transmission	3
Sudan	14	0	2	0	Sporadic Cases	2
Somalia	12	4	1	1	Sporadic Cases	0
Territories**						
occupied Palestinian territory	263	0	1	0	Cluster of cases	1
Region of the Americas						
United States of America	395030	31709	12740	1895	Community Transmission	0
Canada	18433	1384	401	56	Community Transmission	0
Brazil	13717	1661	667	114	Community Transmission	0
Chile	5546	430	48	5	Community Transmission	0

Ecuador	4450	703	242	51	Community Transmission	0
Peru	2954	393	107	15	Community Transmission	0
Mexico	2785	346	141	16	Community Transmission	0
Panama	2249	149	59	4	Community Transmission	0
Dominican Republic	1956	0	98	0	Community Transmission	1
Colombia	1780	201	50	4	Community Transmission	0
Argentina	1715	87	60	7	Community Transmission	0
Costa Rica	483	16	2	0	Cluster of cases	0
Cuba	457	61	12	1	Cluster of cases	0
Uruguay	424	9	7	1	Cluster of cases	0
Honduras	312	7	22	0	Cluster of cases	0
Bolivia (Plurinational State of)	210	16	15	1	Cluster of cases	0
Venezuela (Bolivarian Republic of)	166	1	7	0	Cluster of cases	0
Paraguay	119	4	5	0	Cluster of cases	0
Trinidad and Tobago	107	1	8	0	Cluster of cases	0
El Salvador	93	15	5	1	Cluster of cases	0
Guatemala	87	10	3	0	Cluster of cases	0
Barbados	63	3	3	1	Cluster of cases	0
Jamaica	63	4	3	0	Cluster of cases	0
Bahamas	36	3	6	1	Cluster of cases	0
Guyana	33	2	5	0	Cluster of cases	0
Haiti	27	2	1	0	Cluster of cases	0
Antigua and Barbuda	19	4	2	2	Cluster of cases	0
Dominica	15	0	0	0	Cluster of cases	1
Saint Lucia	14	0	0	0	Sporadic Cases	3
Grenada	12	0	0	0	Cluster of cases	4
Saint Kitts and Nevis	11	1	0	0	Sporadic Cases	0
Suriname	10	0	1	0	Sporadic Cases	5
Belize	8	1	1	0	Sporadic Cases	0
Saint Vincent and the Grenadines	8	1	0	0	Sporadic Cases	0
Nicaragua	6	0	1	0	Pending	2
Territories**						
Puerto Rico	620	47	24	1	Cluster of cases	0
Martinique	152	1	4	0	Cluster of cases	0
Guadeloupe	139	0	8	1	Cluster of cases	1
French Guiana	77	5	0	0	Cluster of cases	0
Aruba	74	3	0	0	Cluster of cases	0
Cayman Islands	45	6	2	1	Cluster of cases	0
United States Virgin Islands	45	2	1	0	Cluster of cases	0
Sint Maarten	40	0	8	0	Sporadic Cases	1

Bermuda	39	0	2	0	Cluster of cases	1
Saint Martin	31	0	2	0	Sporadic Cases	2
Curaçao	14	1	1	0	Sporadic Cases	0
Montserrat	8	2	0	0	Sporadic Cases	0
Turks and Caicos Islands	8	0	1	0	Sporadic Cases	1
Saint Barthélemy	6	0	0	0	Sporadic Cases	9
Falkland Islands (Malvinas)	5	3	0	0	Sporadic Cases	0
Anguilla	3	0	0	0	Sporadic Cases	5
British Virgin Islands	3	0	0	0	Sporadic Cases	8
Bonaire, Sint Eustatius and Saba	2	0	0	0	Sporadic Cases	5
Saint Pierre and Miquelon	1	0	0	0	Sporadic Cases	1
African Region						
South Africa	1845	96	18	5	Community Transmission	0
Algeria	1572	104	205	11	Community Transmission	0
Cameroon	730	175	10	1	Cluster of cases	0
Burkina Faso	384	20	19	1	Cluster of cases	0
Côte d'Ivoire	384	35	3	0	Cluster of cases	0
Niger	342	64	11	0	Cluster of cases	0
Ghana	313	26	6	1	Cluster of cases	0
Nigeria	276	22	6	0	Cluster of cases	0
Mauritius	273	5	7	0	Cluster of cases	0
Senegal	244	7	2	0	Cluster of cases	0
Democratic Republic of the Congo	207	24	20	0	Cluster of cases	0
Kenya	179	7	6	0	Cluster of cases	0
Guinea	164	20	0	0	Cluster of cases	0
Rwanda	110	5	0	0	Sporadic Cases	0
Madagascar	93	1	0	0	Cluster of cases	0
Togo	70	12	3	0	Sporadic Cases	0
Congo	60	15	5	0	Cluster of cases	0
Mali	56	9	6	1	Sporadic Cases	0
Ethiopia	55	3	2	1	Sporadic Cases	0
Uganda	53	1	0	0	Sporadic Cases	0
Zambia	39	0	1	0	Sporadic Cases	6
Eritrea	33	2	0	0	Sporadic Cases	0
Guinea-Bissau	33	0	0	0	Sporadic Cases	2
Liberia	31	17	4	1	Sporadic Cases	0
Benin	26	0	1	0	Sporadic Cases	1
United Republic of Tanzania	25	1	1	0	Sporadic Cases	0
Gabon	24	0	1	0	Sporadic Cases	1
Angola	19	2	2	0	Sporadic Cases	0
Mozambique	17	7	0	0	Sporadic Cases	0
Equatorial Guinea	16	0	0	0	Sporadic Cases	4
Namibia	16	0	0	0	Sporadic Cases	3

Eswatini	12	2	0	0	Sporadic Cases	0
Seychelles	11	0	0	0	Sporadic Cases	2
Zimbabwe	11	0	3	1	Sporadic Cases	1
Central African Republic	10	1	0	0	Sporadic Cases	0
Chad	10	0	0	0	Sporadic Cases	1
Malawi	8	0	1	0	Sporadic Cases	1
Cabo Verde	7	0	1	0	Sporadic Cases	2
Sierra Leone	7	1	0	0	Sporadic Cases	0
Botswana	6	0	1	0	Sporadic Cases	2
Mauritania	6	0	1	0	Sporadic Cases	5
Gambia	4	0	1	0	Sporadic Cases	6
São Tomé and Príncipe	4	0	0	0	Pending	2
Burundi	3	0	0	0	Sporadic Cases	5
South Sudan	1	0	0	0	Pending	3
Territories**						
Réunion	362	4	0	0	Cluster of cases	0
Mayotte	186	2	2	0	Cluster of cases	0
Subtotal for all Regions	**1435486**	**82837**	**85511**	**6287**		
International conveyance (Diamond Princess)	712	0	11	0	Pending	24
Grand total	**1436198**	**82837**	**85522**	**6287**		

*Numbers include both domestic and repatriated cases

†The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

‡Case classifications are based on WHO case definitions for COVID-19.

§Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be upgraded or downgraded as new information becomes available. Not all locations within a given country/territory/area are equally affected; countries/territories/areas experiencing multiple types of transmission are classified in the highest category reported. Within a given transmission category, different countries/territories/areas may have differing degrees of transmission as indicated by the differing numbers of cases, recency of cases, and other factors.

Terms:

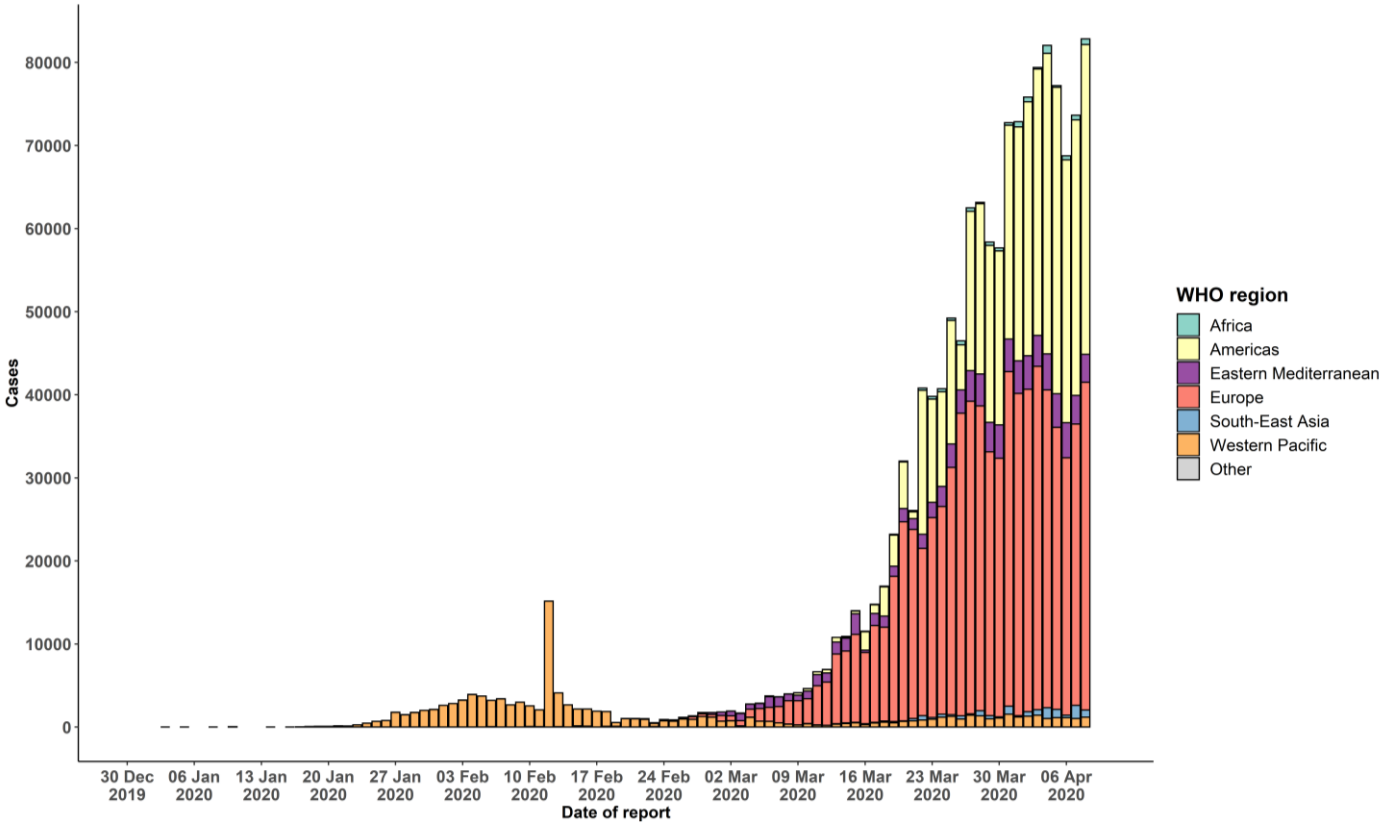
- **No cases**: Countries/territories/areas with no confirmed cases (not shown in table)
- **Sporadic cases**: Countries/territories/areas with one or more cases, imported or locally detected
- **Clusters of cases**: Countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures
- **Community transmission**: Countries/area/territories experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to:
    - Large numbers of cases not linkable to transmission chains
    - Large numbers of cases from sentinel lab surveillance
    - Multiple unrelated clusters in several areas of the country/territory/area

** "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Due to differences in reporting methods, retrospective data consolidation, and reporting delays, the number of new cases may not always reflect the exact difference between yesterday's and today's totals. WHO COVID-19 Situation Reports present official counts of confirmed COVID-19 cases, thus differences between WHO reports and other sources of COVID-19 data using different inclusion criteria and different data cutoff times are to be expected.

Figure 1. Epidemic curve of confirmed COVID-19, by date of report and WHO region through 9 April 2020



STRATEGIC OBJECTIVES

WHO's strategic objectives for this response are to:

- Interrupt human-to-human transmission including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread*;
- Identify, isolate and care for patients early, including providing optimized care for infected patients;
- Identify and reduce transmission from the animal source;
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
- Communicate critical risk and event information to all communities and counter misinformation;
- Minimize social and economic impact through multisectoral partnerships.

*This can be achieved through a combination of public health measures, such as rapid identification, diagnosis and management of the cases, identification and follow up of the contacts, infection prevention and control in health care settings, implementation of health measures for travelers, awareness-raising in the population and risk communication.

PREPAREDNESS AND RESPONSE

- To view all technical guidance documents regarding COVID-19, please go to this webpage.
- WHO has developed interim guidance for laboratory diagnosis, advice on the use of masks during home care and in health care settings in the context of the novel coronavirus (2019-nCoV) outbreak, clinical management, infection prevention and control in health care settings, home care for patients with suspected novel coronavirus, risk communication and community engagement and Global Surveillance for human infection with novel coronavirus (2019-nCoV).
- WHO is working closely with International Air Transport Association (IATA) and have jointly developed a guidance document to provide advice to cabin crew and airport workers, based on country queries. The guidance can be found on the IATA webpage.
- WHO has been in regular and direct contact with Member States where cases have been reported. WHO is also informing other countries about the situation and providing support as requested.
- WHO is working with its networks of researchers and other experts to coordinate global work on surveillance, epidemiology, mathematical modelling, diagnostics and virology, clinical care and treatment, infection prevention and control, and risk communication. WHO has issued interim guidance for countries, which are updated regularly.
- WHO has prepared a disease commodity package that includes an essential list of biomedical equipment, medicines and supplies necessary to care for patients with 2019-nCoV.
- WHO has provided recommendations to reduce risk of transmission from animals to humans.
- WHO has published an updated advice for international traffic in relation to the outbreak of the novel coronavirus 2019-nCoV.
- WHO has activated the R&D blueprint to accelerate diagnostics, vaccines, and therapeutics.
- OpenWHO is an interactive, web-based, knowledge-transfer platform offering online courses to improve the response to health emergencies. COVID-19 courses can be found here and courses in additional national languages here. Specifically, WHO has developed online courses on the following topics:
    - A general introduction to emerging respiratory viruses, including novel coronaviruses (available in Arabic, Chinese, English, French, Russian, Spanish, Hindi, Indian Sign Language, Persian, Portuguese, Serbian and Turkish);
    - Clinical care for Severe Acute Respiratory Infections (available in English, French, Russian, Indonesian and Vietnamese);
    - Health and safety briefing for respiratory diseases - ePROTECT (available in Chinese, English, French, Russian, Spanish, Indonesian and Portuguese);
    - Infection Prevention and Control for Novel Coronavirus (COVID-19) (available in Chinese, English, French, Russian, Spanish, Indonesian, Italian, Japanese, Portuguese and Serbian); and
    - COVID-19 Operational Planning Guidelines and COVID-19 Partners Platform to support country preparedness and response (available in English and coming soon in additional languages).
- WHO is providing guidance on early investigations, which are critical in an outbreak of a new virus. The data collected from the protocols can be used to refine recommendations for surveillance and case definitions, to characterize the key epidemiological transmission features of COVID-19, help understand spread, severity, spectrum of disease, impact on the community and to inform operational models for implementation of countermeasures such as case isolation, contact tracing and isolation. Several protocols are available here. One such protocol is for the investigation of early COVID-19 cases and contacts (the "First Few X (FFX) Cases and contact investigation protocol for 2019-novel coronavirus (2019-nCoV) infection"). The protocol is designed to gain an early understanding of the key clinical, epidemiological and virological characteristics of the first cases of COVID-19 infection detected in any individual country, to inform the development and updating of public health guidance to manage cases and reduce the potential spread and impact of infection.

RECOMMENDATIONS AND ADVICE FOR THE PUBLIC

If you are not in an area where COVID-19 is spreading or have not travelled from an area where COVID-19 is spreading or have not been in contact with an infected patient, your risk of infection is low. It is understandable that you may feel anxious about the outbreak. Get the facts from reliable sources to help you accurately determine your risks so that you can take reasonable precautions (see Frequently Asked Questions). Seek guidance from WHO, your healthcare provider, your national public health authority or your employer for accurate information on COVID-19 and whether COVID-19 is circulating where you live. It is important to be informed of the situation and take appropriate measures to protect yourself and your family (see Protection measures for everyone).

If you are in an area where there are cases of COVID-19 you need to take the risk of infection seriously. Follow the advice of WHO and guidance issued by national and local health authorities. For most people, COVID-19 infection will cause mild illness however, it can make some people very ill and, in some people, it can be fatal. Older people, and those with pre-existing medical conditions (such as cardiovascular disease, chronic respiratory disease or diabetes) are at risk for severe disease (See Protection measures for persons who are in or have recently visited (past 14 days) areas where COVID-19 is spreading).

CASE DEFINITIONS

WHO periodically updates the Global Surveillance for human infection with coronavirus disease (COVID-19) document which includes case definitions.

For easy reference, case definitions are included below.

Suspect case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.
OR
B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;
OR
C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A. A suspect case for whom testing for the COVID-19 virus is inconclusive.
    a. Inconclusive being the result of the test reported by the laboratory.
OR
B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

- Technical guidance for laboratory testing can be found here.

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days

after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment[1]; OR
4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days *after the date on which the sample was taken* which led to confirmation.

[1] World Health Organization. Infection prevention and control during health care when COVID-19 is suspected https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125

Exhibit B

April 10, 2020 U.S. Immigration & Customs Enforcement, ICE Guidance on COVID-19: Confirmed Cases

Official Website of the Department of Homeland Security

ICE

Report Crimes: Email or Call 1-866-DHS-2-ICE

NOTICE

Click here for the latest ICE guidance on COVID-19

ICE Guidance on COVID-19

Overview & FAQs | Confirmed Cases | Previous Statements

Share

DETAINEES

50

There have been 50 confirmed cases of COVID-19 among those in ICE custody*.

- 2 detainees in Bergen County Jail (Hackensack, NJ)
- 4 detainees in Buffalo Federal Detention Facility (Buffalo, NY)
- 7 detainees in Elizabeth Detention Center (Elizabeth, NJ)
- 2 detainees in Essex County Correctional Facility (Newark, NJ)
- 3 detainees in Florence Detention Center (Florence, AZ)
- 5 detainees in Hudson County Jail (Kearny, NJ)
- 1 detainee in Irwin County Detention Center (Ocilla, GA)
- 1 detainee in Krome Detention Center (Miami, FL)
- 2 detainees in La Palma Correctional Facility (Eloy, AZ)
- 1 detainee in LaSalle Correctional Center (Olla, LA)
- 10 detainees in Otay Mesa Detention Center (San Diego, CA)
- 5 detainees in Pike County Correctional Facility (Hawley, PA)
- 1 detainee in Pine Prairie ICE Processing Center (Pine Prairie, LA)
- 1 detainee in St. Clair County Jail (Huron, MI)
- 2 detainees in Stewart Detention Center (Lumpkin, GA)
- 1 detainee in Winn Correctional Center (Winnfield, LA)
- 1 detainee in York County Prison (York, PA)
- 1 ICE detainee at local hospital (Miami, FL)

*Some detainees may no longer be in ICE custody.

Updated 04/10/2020 9:20am

ICE EMPLOYEES AT DETENTION CENTERS

15

There have been 15 confirmed cases of COVID-19 among ICE employees working in ICE detention facilities.

- 2 at Aurora Contract Detention Facility (Aurora, CO)
- 1 at Butler County Jail (Hamilton, OH)
- 1 at Elizabeth Contract Detention Facility (Elizabeth, NJ)
- 1 at Houston Contract Detention Facility (Houston, TX)
- 1 at Hudson County Jail (Kearny, NJ)
- 9 at Alexandria Staging Facility (Alexandria, LA)

Updated 04/09/2020 6:00pm

ICE EMPLOYEES

65

There have been 65 confirmed cases of COVID-19 among ICE employees not assigned to detention facilities.

Updated 04/09/2020 6:00pm

Last Reviewed/Updated: 04/10/2020

Exhibit C

March 24, 2020 Ken Klippenstein, Exclusive: ICE Detainees Are Being Quarantined, The Nation

Exclusive: ICE Detainees Are Being Quarantined

thenation.com/article/society/corona-covid-immigration-detention/

By Ken Klippenstein Twitter March 24, 2020

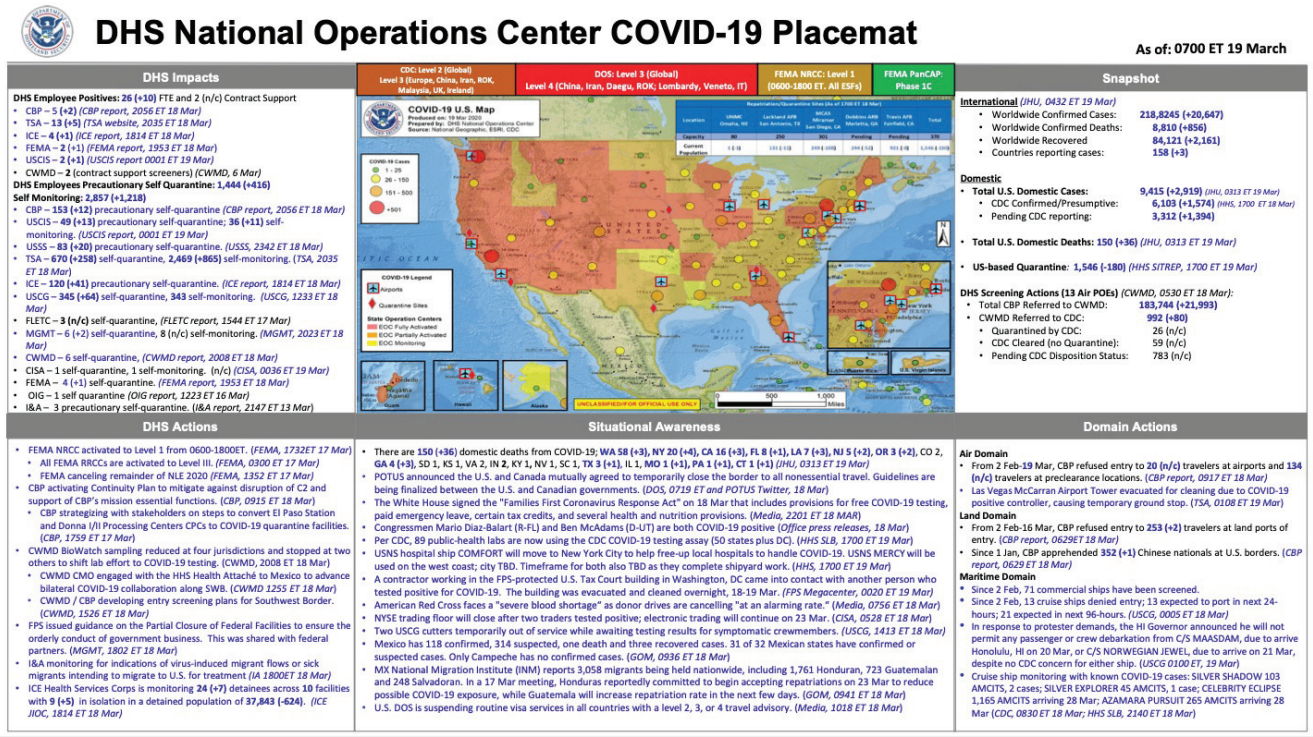
March 24, 2020

Men stand in a US Immigration and Border Enforcement detention center in McAllen, Texas. (Josh Dawsey / The Washington Post via AP, Pool)

EDITOR'S NOTE: The Nation believes that helping readers stay informed about the impact of the coronavirus crisis is a form of public service. For that reason, this article, and all of our coronavirus coverage, is now free. Please subscribe to support our writers and staff, and stay healthy.

Multiple Immigration and Customs Enforcement (ICE) detainees have been put in isolation for medical reasons, according to an internal Department of Homeland Security (DHS) coronavirus report obtained exclusively by *The Nation*.

The report, marked "For Official Use Only" and dated March 19, states that ICE's Health Services Corps had isolated nine detainees and that it was monitoring 24 more in 10 different ICE facilities.



DHS National Operations Center COVID-19 Placemat

As of: 0700 ET 19 March

DHS Impacts

DHS Employee Positives: 26 (+10) FTE and 2 (n/c) Contract Support
- CBP – 5 (+2) *(CBP report, 2056 ET 18 Mar)*
- TSA – 13 (+5) *(TSA website, 2035 ET 18 Mar)*
- ICE – 4 (+1) *(ICE report, 1814 ET 18 Mar)*
- FEMA – 2 (+1) *(FEMA report, 1953 ET 18 Mar)*
- USCIS – 2 (+1) *(USCIS report 0001 ET 19 Mar)*
- CWMD – 2 (contract support screeners) *(CWMD, 6 Mar)*

DHS Employees Precautionary Self Quarantine: 1,444 (+416)

Self Monitoring: 2,857 (+1,218)
- CBP – 153 (+12) precautionary self-quarantine *(CBP report, 2056 ET 18 Mar)*
- USCIS – 49 (+13) precautionary self-quarantine; 36 (+11) self-monitoring. *(USCIS report, 0001 ET 19 Mar)*
- USSS – 83 (+20) precautionary self-quarantine. *(USSS, 2342 ET 18 Mar)*
- TSA – 670 (+258) self-quarantine, 2,469 (+865) self-monitoring. *(TSA, 2035 ET 18 Mar)*
- ICE – 120 (+41) precautionary self-quarantine. *(ICE report, 1814 ET 18 Mar)*
- USCG – 345 (+64) self-quarantine, 343 self-monitoring. *(USCG, 1233 ET 18 Mar)*
- FLETC – 3 (n/c) self-quarantine, *(FLETC report, 1544 ET 17 Mar)*
- MGMT – 6 (+2) self-quarantine, 8 (n/c) self-monitoring. *(MGMT, 2023 ET 18 Mar)*
- CWMD – 6 self-quarantine, *(CWMD report, 2008 ET 18 Mar)*
- CISA – 1 self-quarantine, 1 self-monitoring. (n/c) *(CISA, 0036 ET 19 Mar)*
- FEMA – 4 (+1) self-quarantine. *(FEMA report, 1953 ET 18 Mar)*
- OIG – 1 self quarantine *(OIG report, 1223 ET 16 Mar)*
- I&A – 3 precautionary self-quarantine. *(I&A report, 2147 ET 13 Mar)*

CDC: Level 2 (Global) Level 3 (Europe, China, Iran, ROK, Malaysia, UK, Ireland) | DOS: Level 3 (Global) Level 4 (China, Iran, Daegu, ROK; Lombardy, Veneto, IT) | FEMA NRCC: Level 1 (0600-1800 ET. All ESFs) | FEMA PanCAP: Phase 1C

COVID-19 U.S. Map

Snapshot

International *(JHU, 0432 ET 19 Mar)*
- Worldwide Confirmed Cases: 218,8245 (+20,647)
- Worldwide Confirmed Deaths: 8,810 (+856)
- Worldwide Recovered 84,121 (+2,161)
- Countries reporting cases: 158 (+3)

Domestic
- **Total U.S. Domestic Cases:** 9,415 (+2,919) *(JHU, 0313 ET 19 Mar)*
  - CDC Confirmed/Presumptive: 6,103 (+1,574) *(HHS, 1700 ET 18 Mar)*
  - Pending CDC reporting: 3,312 (+1,394)
- **Total U.S. Domestic Deaths: 150 (+36)** *(JHU, 0313 ET 19 Mar)*
- **US-based Quarantine: 1,546 (-180)** *(HHS SITREP, 1700 ET 19 Mar)*

DHS Screening Actions (13 Air POEs) *(CWMD, 0530 ET 18 Mar):*
- Total CBP Referred to CWMD: 183,744 (+21,993)
- CWMD Referred to CDC: 992 (+80)
  - Quarantined by CDC: 26 (n/c)
  - CDC Cleared (no Quarantine): 59 (n/c)
  - Pending CDC Disposition Status: 783 (n/c)

DHS Actions
- FEMA NRCC activated to Level 1 from 0600-1800ET. *(FEMA, 1732ET 17 Mar)*
  - All FEMA RRCCs are activated to Level III. *(FEMA, 0300 ET 17 Mar)*
  - FEMA canceling remainder of NLE 2020 *(FEMA, 1352 ET 17 Mar)*
- CBP activating Continuity Plan to mitigate against disruption of C2 and support of CBP's mission essential functions. *(CBP, 0915 ET 18 Mar)*
  - CBP strategizing with stakeholders on steps to convert El Paso Station and Donna I/II Processing Centers CPCs to COVID-19 quarantine facilities. *(CBP, 1759 ET 17 Mar)*
- CWMD BioWatch sampling reduced at four jurisdictions and stopped at two others to shift lab effort to COVID-19 testing. (CWMD, 2008 ET 18 Mar)
  - CWMD CMO engaged with the HHS Health Attaché to Mexico to advance bilateral COVID-19 collaboration along SWB. *(CWMD 1255 ET 18 Mar)*
  - CWMD / CBP developing entry screening plans for Southwest Border. *(CWMD, 1526 ET 18 Mar)*
- FPS issued guidance on the Partial Closure of Federal Facilities to ensure the orderly conduct of government business. This was shared with federal partners. *(MGMT, 1802 ET 18 Mar)*
- I&A monitoring for indications of virus-induced migrant flows or sick migrants intending to migrate to U.S. for treatment *(IA 1800ET 18 Mar)*
- ICE Health Services Corps is monitoring 24 (+7) detainees across 10 facilities with 9 (+5) in isolation in a detained population of 37,843 (-624). *(ICE JIOC, 1814 ET 18 Mar)*

Situational Awareness
- There are 150 (+36) domestic deaths from COVID-19; WA 58 (+3), NY 20 (+4), CA 16 (+3), FL 8 (+1), LA 7 (+3), NJ 5 (+2), OR 3 (+2), CO 2, GA 4 (+3), SD 1, KS 1, VA 2, IN 2, KY 1, NV 1, SC 1, TX 3 (+1), IL 1, MO 1 (+1), PA 1 (+1), CT 1 (+1) *(JHU, 0313 ET 19 Mar)*
- POTUS announced the U.S. and Canada mutually agreed to temporarily close the border to all nonessential travel. Guidelines are being finalized between the U.S. and Canadian governments. *(DOS, 0719 ET and POTUS Twitter, 18 Mar)*
- The White House signed the "Families First Coronavirus Response Act" on 18 Mar that includes provisions for free COVID-19 testing, paid emergency leave, certain tax credits, and several health and nutrition provisions. *(Media, 2201 ET 18 MAR)*
- Congressmen Mario Diaz-Balart (R-FL) and Ben McAdams (D-UT) are both COVID-19 positive *(Office press releases, 18 Mar)*
- Per CDC, 89 public-health labs are now using the CDC COVID-19 testing assay (50 states plus DC). *(HHS SLB, 1700 ET 19 Mar)*
- USNS hospital ship COMFORT will move to New York City to help free-up local hospitals to handle COVID-19. USNS MERCY will be used on the west coast; city TBD. Timeframe for both also TBD as they complete shipyard work. *(HHS, 1700 ET 19 Mar)*
- A contractor working in the FPS-protected U.S. Tax Court building in Washington, DC came into contact with another person who tested positive for COVID-19. The building was evacuated and cleaned overnight, 18-19 Mar. *(FPS Megacenter, 0020 ET 19 Mar)*
- American Red Cross faces a "severe blood shortage" as donor drives are cancelling "at an alarming rate." *(Media, 0756 ET 18 Mar)*
- NYSE trading floor will close after two traders tested positive; electronic trading will continue on 23 Mar. *(CISA, 0528 ET 18 Mar)*
- Two USCG cutters temporarily out of service while awaiting testing results for symptomatic crewmembers. *(USCG, 1413 ET 18 Mar)*
- Mexico has 118 confirmed, 314 suspected, one death and three recovered cases. 31 of 32 Mexican states have confirmed or suspected cases. Only Campeche has no confirmed cases. *(GOM, 0936 ET 18 Mar)*
- MX National Migration Institute (INM) reports 3,058 migrants being held nationwide, including 1,761 Honduran, 723 Guatemalan and 248 Salvadoran. In a 17 Mar meeting, Honduras reportedly committed to begin accepting repatriations on 23 Mar to reduce possible COVID-19 exposure, while Guatemala will increase repatriation rate in the next few days. *(GOM, 0941 ET 18 Mar)*
- U.S. DOS is suspending routine visa services in all countries with a level 2, 3, or 4 travel advisory. *(Media, 1018 ET 18 Mar)*

Domain Actions

Air Domain
- From 2 Feb-19 Mar, CBP refused entry to 20 (n/c) travelers at airports and 134 (n/c) travelers at preclearance locations. *(CBP report, 0917 ET 18 Mar)*
- Las Vegas McCarran Airport Tower evacuated for cleaning due to COVID-19 positive controller, causing temporary ground stop. *(TSA, 0108 ET 19 Mar)*

Land Domain
- From 2 Feb-16 Mar, CBP refused entry to 253 (+2) travelers at land ports of entry. *(CBP report, 0629ET 18 Mar)*
- Since 1 Jan, CBP apprehended 352 (+1) Chinese nationals at U.S. borders. *(CBP report, 0629 ET 18 Mar)*

Maritime Domain
- Since 2 Feb, 71 commercial ships have been screened.
- Since 2 Feb, 13 cruise ships denied entry; 13 expected to port in next 24-hours; 21 expected in next 96-hours. *(USCG, 0005 ET 18 Mar)*
- In response to protester demands, the HI Governor announced he will not permit any passenger or crew debarkation from C/S MAASDAM, due to arrive Honolulu, HI on 20 Mar, or C/S NORWEGIAN JEWEL, due to arrive on 21 Mar, despite no CDC concern for either ship. *(USCG 0100 ET, 19 Mar)*
- Cruise ship monitoring with known COVID-19 cases: SILVER SHADOW 103 AMCITS, 2 cases; SILVER EXPLORER 45 AMCITS, 1 case; CELEBRITY ECLIPSE 1,165 AMCITS arriving 28 Mar; AZAMARA PURSUIT 265 AMCITS arriving 28 Mar (*CDC, 0830 ET 18 Mar; HHS SLB, 2140 ET 18 Mar*)

An internal DHS coronavirus report, obtained by The Nation, states that ICE's Health Services Corps had isolated 9 detainees.

The document does not specify what illness these individuals are being monitored for, and an ICE spokesperson said that "detainees can be quarantined as a result of any variety of communicable diseases."

However, the document is titled "DHS National Operations Center COVID-19 Placemat," which suggests that the agency's actions are in direct response to the Covid-19 pandemic.

Related Article

[Cuba's Welcome to a Covid-19-Stricken Cruise Ship Reflects a Long Pattern of Global Humanitarian Commitment](#)

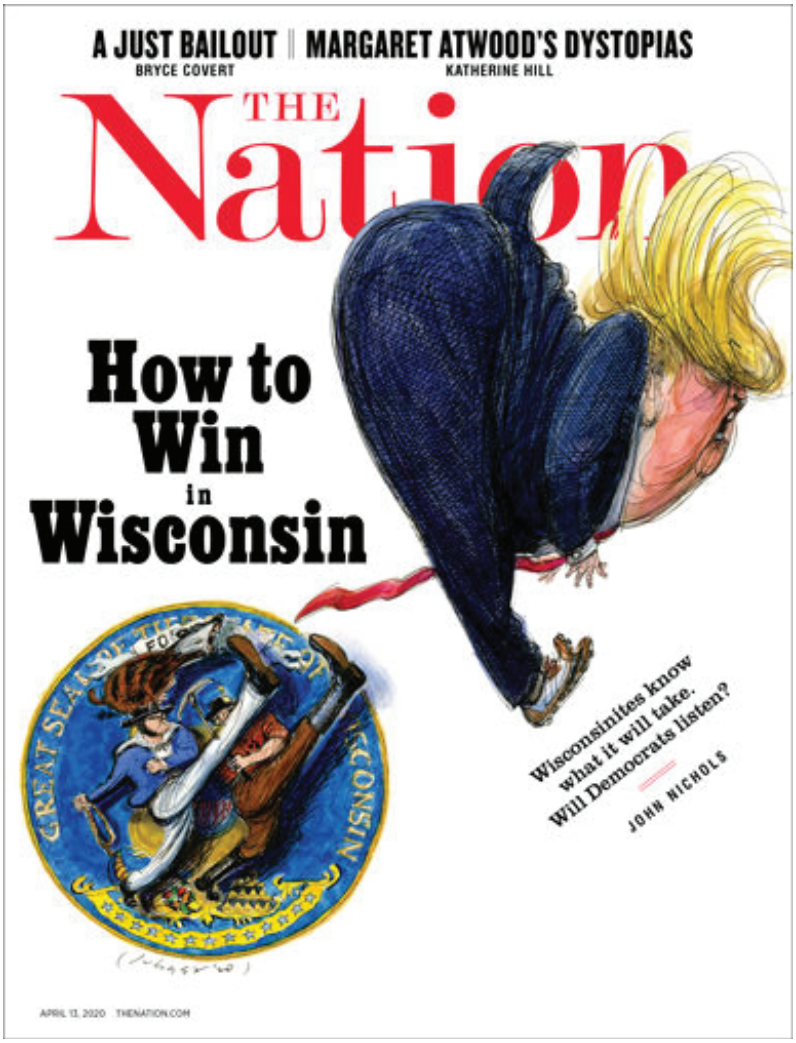
Peter Kornbluh

In addition, the document says Customs and Border Protection (CBP) is working to convert several of its major border facilities into quarantine facilities. One thousand, four hundred and forty-four officials with ICE and CBP's parent agency, the DHS, were in "precautionary self-quarantine" at the time of the document's writing, including 153 CBP officials, the report says.

The document was provided by a federal intelligence official on condition of anonymity to avoid professional reprisal.

The report goes on to state that the current number of detainees in ICE custody is 37,843. Among each of the DHS's sub-agencies, the one with the most employees in self-quarantine is the Transportation Security Administration, at 670. The US Coast Guard ranks second, with 345 employees in self-quarantine, followed by CBP and then ICE.

Current Issue



View our current issue

Unsanitary conditions in both ICE and CBP detention facilities are well-documented, and have led to concerns about facilitating the spread of coronavirus. In July, a DHS Inspector General report found "dangerous overcrowding" and squalid conditions among its southern border facilities. Last week, two doctors who work for the DHS wrote a letter to Congress warning of an "imminent risk to the health and safety of immigrant detainees" as well as the general public in the event that the coronavirus spreads among ICE detention facilities.

The letter went on to warn of a "tinderbox scenario of a large cohort of people getting sick all at once." One day before the letter was sent, ICE informed Congress that at least one of its employees had tested positive for the coronavirus.

In June, I obtained an internal ICE memo describing multiple deaths in ICE custody as having been preventable. The memo, sent from an ICE Health Services Corps (IHSC) official to ICE's then-director, Matthew Albence, in December 2018, stated: "IHSC [ICE's Health Services Corps] is severely dysfunctional and unfortunately preventable harm and death to detainees has occurred."

Despite these conditions, ICE insists no detainees have been found to have the coronavirus.

"At this time, no detainees have tested positive for the virus," Danielle Bennett, a spokeswoman for ICE, told *The Nation* on March 23. "Detainees can be quarantined as a result of any variety of communicable diseases, not just Covid-19."

Asked to clarify if each of the ICE detainees presently in isolation have been tested for Covid-19, Bennet replied: "Yes, testing is being done in accordance with CDC guidelines."

However, the report obtained by *The Nation* is titled "DHS National Operations Center COVID-19 Placemat," and the rest of the document appears to pertain entirely and explicitly to the coronavirus. It is unclear why it would include detainee isolation data pertaining to another illness. (Aside from ICE, the report does not mention detainee isolation numbers in any other DHS agency.)

Under pressure to respond to the epidemic, ICE says it has dramatically scaled back its enforcement activities. But many say that's not enough.

In addition to the two DHS doctors who warned Congress about the dangers posed by the detention facilities, 3,000 medical professionals signed an open letter urging ICE to release its detainees in order to prevent the spread of the coronavirus. 51 ICE detainees sent a letter to rights groups warning that they were being exposed to flu-like symptoms. And it's not just advocates—ICE itself appears concerned, having requested 45,000 respirators last week.

The document provides further insights into DHS's pandemic response. One segment of the report says that DHS's Intelligence & Analysis is "monitoring for indications of virus-induced migrant flows or sick migrants intending to migrate to U.S. for treatment."

Intelligence & Analysis is unique among DHS agencies for being the only one that is part of the US Intelligence Community. As the only spy agency within DHS, Intelligence & Analysis enjoys access to classified information as well as sophisticated intelligence capabilities.

The report also notes that CBP has activated its continuity plan. *The Nation* recently published CBP's pandemic response plan, which contains a continuity plan in anticipation of a substantial loss of personnel capacity as well as morale due to illness.

One passage in the pandemic response plan states: “Many Americans will die from the virus, spreading fear and panic among the population, including CBP employees…. Pandemic influenza is expected to cause massive disruptions in travel and commerce, and may challenge the essential stability of governments and society. In spite of this, CBP must continue to carry out its priority mission to prevent the entry of terrorists and their weapons, regardless of the circumstances.”

Exhibit D

March 19, 2020 Letter from Drs. Scott A. Allen & Josiah Rich to Rep. Bennie Thompson et al.

Scott A. Allen, MD, FACP
Professor Emeritus, Clinical Medicine
University of California Riverside School of Medicine
Medical Education Building
900 University Avenue
Riverside, CA 92521

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 reports[2] 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

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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

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[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 transferred170 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, "Coronovirus (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.

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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

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[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.

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[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

Exhibit E

March 30, 2020 Yeganeh Torbati, Dara Lind & Jack Gillum, In a 10-Day Span, ICE Flew This Detainee Across the Country – Nine Times, Big Easy Magazine

In a 10-Day Span, ICE Flew This Detainee Across the Country — Nine Times

Yeganeh Torbati, Dara Lind and Jack Gillum, ProPublica
March 30th 2020

Courtesy of Dr. Asgari's homepage

This article was originally published in ProPublica, a nonprofit newsroom that investigates abuses of power.

Less than two weeks ago, the Trump administration urged Americans to avoid nonessential travel to prevent the spread of the coronavirus. Major airlines slashed their routes. All the while, Sirous Asgari took nine different flights around the country.

None of them was by choice.

Asgari bounced around on chartered jets from Louisiana to Texas to New Jersey — a circuitous journey arranged by U.S. Immigration and Customs Enforcement, which has custody of the 59-year-old Iranian man. The federal agency continues to shuffle detainees around the nation, exposing them and others to possible infection.

As panic grows inside ICE facilities over the potential spread of the virus, some immigration attorneys said they were promised by local ICE officials last week that detainee transfers would halt temporarily. But the government has continued the practice anyway, data and interviews show.

In fact, two air charter companies known to be used by ICE continue to fly between airports known for detainee transfers, a ProPublica analysis of flight records shows. The charter companies, Swift Air and World Atlantic Airlines, have operated at least 16 flights between those locations since March 16 — the date when U.S. officials implored travelers to avoid discretionary travel and not gather in groups larger than 10 people. Asgari boarded at least one commonly used Swift Air passenger jet, a Boeing 737.

ProPublica's findings raise new concerns as health experts urge minimizing travel. Once a coronavirus infection takes hold in a detention center — often a cramped facility with limited health care — experts and detainees alike worry that its spread becomes inevitable. (ICE has announced two confirmed cases of COVID-19 among those in its custody, both in facilities in New Jersey, and three cases among ICE detention staff, in New Jersey, Colorado and Texas. Late on Thursday, a federal judge ordered the release of 10 ICE detainees held in New Jersey jails where COVID-19 cases had been confirmed.)

The risk goes beyond the 38,000-plus ICE detainees. It extends to detention center guards, people at local jails used for ICE detention and pretrial detainees who haven't been convicted of a crime.

"It's quite dangerous" to fly detainees around while much of the country is locked down, said Dr. Robert Greifinger, a New York physician who used to inspect ICE facilities as a Department of

Homeland Security contractor. “In many states, particularly the states along the coasts, there are stay-at-home rules, and for ICE to be moving people to those areas or from those areas is dangerous not just for the detainees but for the staff and the communities into which the detainees are brought.”

ICE did not respond to questions from ProPublica for this story. On its website, ICE said it follows guidelines from the Centers for Disease Control and Prevention on screening and testing for the coronavirus.

Federal immigration officials have long transported detainees across America by air and bus depending on the demand for beds and to respond to medical needs and security concerns. “For the most part, ICE’s tempo has been to move detainees in a way that thinks of them more as widgets, or as supply chain issues, than human beings,” said a former senior ICE official, who asked for anonymity to speak candidly.

In Asgari’s case, the recent disruption in international air travel appears to have contributed to his numerous flights and delayed his deportation.

Asgari — who has a history of lung infections and pneumonia — has been held at four detention facilities in three states (Ohio, Louisiana and Texas). He’s also been placed on at least nine ICE flights across the country just since March 17. ProPublica used flight records to confirm Asgari’s account of his cross-country travels via Swift Air.

ProPublica discovered additional detainee trips, like Asgari’s, by analyzing flight patterns from aircraft-tracking services like FlightAware and ADS-B Exchange. Mapping software showed no significant slowdown in recent journeys between the Alexandria Staging Facility in Louisiana and similar detention facilities near Miami and Newark, New Jersey, as well as Laredo and Brownsville in Texas.

Some ICE transfers came before the epidemic erupted, but their timing offered opportunities for infection. (In one case on March 1, a detainee was sent from El Paso, Texas, to Tacoma, Washington, via the Seattle-Tacoma International Airport, as the state saw its first coronavirus deaths.) The flights have continued even as many of the areas where detainees are held have gone into lockdown.

"This back-and-forth, massive movement of detainees under this coronavirus is absolutely dangerous," Asgari said in a phone interview this week from Louisiana, where he is held pending deportation. "They are endangering the lives of all these people, including myself, and nobody cares. Why?"

Asgari, a materials science and engineering professor, was arrested by ICE agents in November after his acquittal on federal charges of divulging trade secrets. He, his family and his lawyers have pleaded with ICE to release him as the virus spreads because of his age and health history.

ICE officials have said they will scale back arrests in response to the coronavirus, but they told ProPublica on Monday that they have not yet reevaluated policies regarding those currently in detention.

Transfer decisions are often made by regional ICE field offices, the former senior ICE official said, sometimes without the knowledge of headquarters.

According to lawyers, ICE officials in at least two field offices said last week that they would pause detainee transfers but didn't follow through.

"A week ago, [the El Paso ICE field office] told us they wouldn't be transferring anybody else," said Heidi Cerneka of Las Americas Immigrant Advocacy Center. "And then the very next day, we had a client enter in contact with us in a panic because they told her she was going to be transferred."

Last Friday, Las Americas attorneys say, a different Las Americas client was transferred without notice from El Paso to a nearby detention center in Otero, New Mexico. On Monday, a 60-year-old client told Las Americas she was placed on a full plane of detainees to be transferred to Louisiana, then removed by ICE officers and returned to El Paso without explanation.

In northern Florida on March 18, an ICE official told Mary Yanik, a lawyer with the New Orleans Workers' Center for Racial Justice, that a detainee's scheduled March 19 transfer had been postponed because they were canceling "all movement of anybody for at least another week," according to lawyer's notes shared with ProPublica. On March 25, the detainee was transferred and Yanik was not notified.

Neither the El Paso nor Miami ICE field offices replied to a request for comment.

Detainees are supposed to be medically evaluated at each new facility, but the detention centers often do not have interpreters or medical records are not passed along.

At the Krome Processing Center, a Miami-area facility where detainees are often sent shortly before deportation, lawyer Bud Conlin said recently transferred detainees reported only temperature checks. Accounts suggest that when detainees are quarantined for coronavirus symptoms, it's often after they've been in transit with others.

In a sworn statement filed this week as part of a federal lawsuit, attorney Keren Zwick of the National Immigrant Justice Center recounted one California detainee's report.

After sleeping eight to a cell in an Otay Mesa detention center, the detainee was bused nearly three hours to Adelanto with 30 other men, two of whom were "coughing and visibly sick." The sick detainees were separated only after arriving at Adelanto. (On Monday, the detainee was brought back to the Otay Mesa facility. He told his lawyer he received no medical checks after either transfer.)

For three months, Asgari was held at a facility in Youngstown, Ohio, and transferred in mid-February to the crowded Seneca County Jail, also in Ohio. Dozens of people shared one shower and four bathroom stalls, he said. The Seneca County Sheriff's Office did not respond to a voicemail requesting comment.

While at Seneca, Asgari fell ill but recovered after treatment with antibiotics, he said.

Around March 10, Asgari was transferred from Seneca County to the Alexandria facility, a 400-bed ICE site in central Louisiana used as a deportation hub. Asgari believed that his deportation was imminent.

Dozens of people move in and out each day in the bare-bones facility with no outdoor space, Asgari said. "This facility, if the virus gets in, it would be a disaster," he said. On Thursday, a sign saying the area was under medical observation was put on the door of Asgari's pod, and a nurse took the temperatures of everyone in that pod. Detainees grew scared and frustrated, and the nurse did not explain.

A spokesman for GEO Group, which runs Alexandria, did not answer specific questions, but the company has said in a statement that its facilities have access to hand-washing facilities and soap, and include coronavirus screening during intake.

ICE facilities have a long history of mishandling infectious diseases that can rapidly spread outside their walls, endangering both detainees and the communities in which they are located. In audio obtained by ProPublica, an immigrant detained by ICE in New Jersey complained that he and other detainees are on a hunger strike to try to obtain soap and toilet paper in the midst of the pandemic.

Asgari said he was flown on March 17 from Louisiana to the Boston area, where some immigrants disembarked and others came onboard. They then flew to New Jersey, where Asgari said he was supposed to disembark for an eventual flight from New York to Iran.

Instead, the plane was held for hours in New Jersey, and he could not exit. Asgari said he was told by an ICE officer that his flight to Iran had been canceled. From New Jersey, Asgari and the other immigrants flew to Texas, and from Texas to Louisiana.

iAero Airways, which acquired Swift Air in 2018, did not respond to requests for comment. World Atlantic Airlines, another ICE flight operator, also did not respond. Neither company has contracts that show up in federal spending databases, which would disclose how much the operations cost taxpayers.

Several days later, Asgari traveled from Louisiana to Pennsylvania, where he said dozens of immigrants boarded the plane, and on to Brownsville. While most other passengers were deported to Mexico, he and a handful of others were transferred to ICE's Port Isabel Detention Center, where they slept on a concrete floor.

The next morning, March 24, he flew from Brownsville to Toledo, Ohio, where he was supposed to disembark. At the last minute, he said ICE officials kept him on the plane, which then went on to Richmond, Virginia, and finally back to Louisiana. At each stop, he said the plane picked up more immigrants and was full when it finally landed late on Tuesday in Louisiana.

The ICE deportation officer assigned to Asgari's case did not respond to a voicemail requesting comment. The officer, Scott Wichrowski, told Asgari's attorney, Edward Bryan, on Thursday that

his deportation is scheduled to occur “no later than early April,” according to an email seen by ProPublica.

But Bryan said Asgari’s experience demonstrates that ICE can’t guarantee his deportation date and that he should be released on bond in the meantime.

Asgari said he would be happy to arrange his own travel back to Iran if ICE would release him.

David McSwane and Perla Trevizo contributed reporting.

Exhibit F

December 7, 2018 Noah Lanard, A Haitian Asylum-Seeker Did Everything Right. ICE Sent Him to a Windowless Jail Cell., Mother Jones

A Haitian Asylum-Seeker Did Everything Right. ICE Sent Him to a Windowless Jail Cell.

motherjones.com/politics/2018/12/a-haitian-asylum-seeker-did-everything-right-ice-sent-him-to-a-windowless-jail-cell/

December 7, 2018

Melody Hart speaks to Ansly Damus via webcam at the Geauga County Safety Center.Courtesy of Gary Benjamin and Melody Hart

For indispensable reporting on the coronavirus crisis and more, subscribe to *Mother Jones*' newsletters.

Somewhere in an Ohio jail, Ansly Damus was listening to Melody Hart and Gary Benjamin. It was late October, and they were telling Damus that the trees were changing colors. Damus, a 42–year-old asylum-seeker from Haiti, had not been allowed outside in two years.

Hart and Benjamin, a local married couple in their sixties who had become Damus' biggest allies and advocates in the United States, didn't know exactly where Damus was. They'd been making the hour-long drive from Cleveland to visit Damus in the small town of Chardon nearly every week for the past nine months, but they'd never actually seen him face to face. Inmates in the Geauga County jail must speak to friends and family through webcams and small monitors. Hart and Benjamin were sitting in a narrow room with 10 screens. As they talked to Damus, a timer on Benjamin's cell phone counted down from 30 minutes, after which the video line would be cut.

Damus mentioned that his eight-year-old daughter back in Haiti had asked him for a tablet. Damus, of course, had no way to send one; he couldn't even call her or mail her letters. But Hart and Benjamin said they had an extra tablet and promised to send it to her. As on all their visits, their goal was to lift his spirits. It was not an easy task. He lived in a windowless room from which he could not see the sun or the moon. As the visit wrapped up, they reassured Damus that they would pray for him and his quick release.

Back in July 2016, when he started his journey to America, he imagined that upon arriving at the border, he would spend three days in government custody before being released. Instead, he was sent to a county jail in Ohio, a state he had no connection to or intention to visit. In Haiti, Damus had taught ethics at a professional school and math and physics to middle schoolers but said he fled in 2014 after a local gang beat him for criticizing a corrupt politician. He first traveled to Brazil and later began a robbery-plagued, three-month trek across the Americas before finally arriving at the border in California in late 2016.

There, he did exactly what US immigration officials have consistently told asylum-seekers to do: He came to an official port of entry and asked for protection from the persecution he'd faced back home, and a judge granted him asylum. What's happened to him since is an extreme illustration of the distortion of the asylum process under President Donald Trump. US Immigration and Customs Enforcement, under its new Trump-appointed leadership, appealed Damus' asylum decision, and while the case was being heard, ICE kept him locked up in Chardon. After the judge upheld his asylum grant, ICE again appealed, and Damus remained at the jail. The prolonged incarceration was emblematic of an administration that does everything in its power to keep asylum-seekers in jail, rather than releasing them with ankle monitors or other forms of supervision.

And so Damus languished in the jail, a mild-mannered former teacher among criminals, for three months, then six. For one year, then two. All the while, he was never allowed to step outside for recreation. Criminals in the jail were sometimes allowed to leave for work, but Damus, as an ICE detainee, was not. Until he started using an elaborate system, he couldn't even communicate with his family.

When Hart and Benjamin left the jail, Damus returned to his cell, where he faced the prospect of many more weeks or months in confinement—if he wasn't deported first.

Damus arrived at the Calexico, California, border crossing two weeks before Trump was elected president. It was the end of a two-year journey from Haiti. He initially lived in a refugee camp in Brazil before finding short-term work as an electrician and construction worker. After about 18 months, he traveled overland to Peru and Colombia, where he was robbed for the first time. He journeyed through Central America with a group of about 50 migrants from Cuba, Benin, Nepal, and elsewhere. In Nicaragua, he was robbed again during a three-week trek through the mountains. In Guatemala, he had to bribe the police to continue north.

In October 2016, he arrived at the California border and went to the port of entry in Calexico, a small town more than 100 miles east of San Diego. US and international law protect migrants' right to request asylum, and Trump administration officials have repeatedly urged asylum-seekers to go to ports of entry. Once in the United States, Damus was quickly transferred to the Geauga County jail to await his asylum hearing.

The entrance to the Geauga County jail in Chardon, Ohio.
Noah Lanard

Shortly before Trump took office, ICE denied Damus' first parole request, on the grounds that he was a flight risk because he lacked sufficient community ties. For the next year, Damus was on his own, aside from assistance from his Ohio immigration lawyer, Elizabeth Ford. Convicted criminals came and went as he lived in the windowless room that held 20 prisoners and, to him, felt saturated with carbon dioxide. Each day brought the same routine: Lights on at 6, head count, breakfast at 7, dinner at 5, head count, lights out at 11. He was humiliated, ashamed, and cut off from his wife and two young children in Haiti. International calls and letters were not allowed. For hope, he returned to a passage from the Book of Hebrews that assures that "discipline always seems painful…at the time, but later it yields the peaceful fruit of righteousness." For strength, he turned to Job, who bore burdens even greater than his.

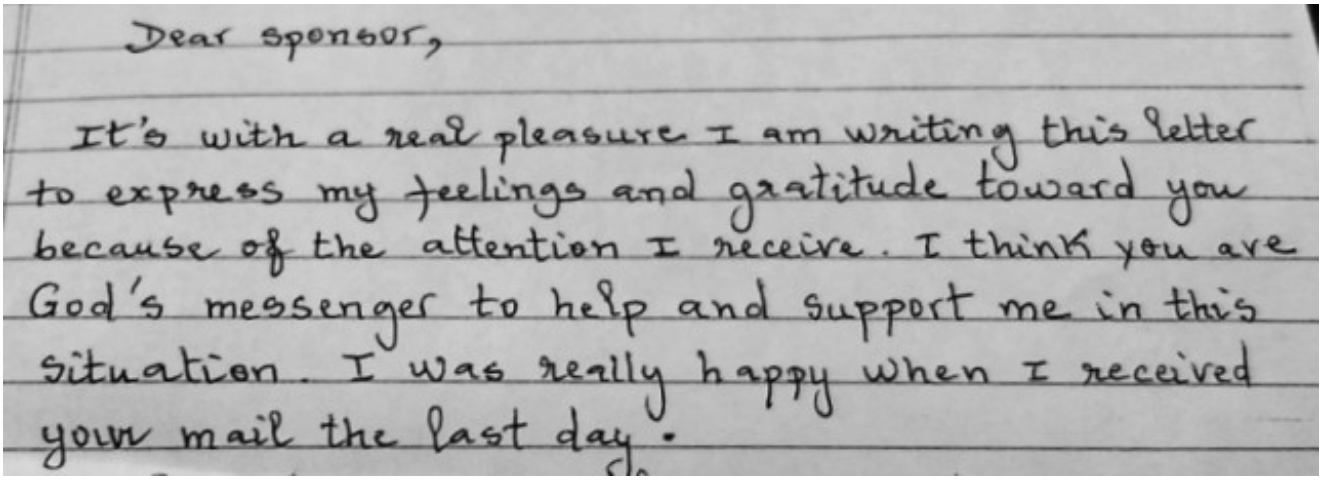
Eighty-six percent of Haitians were denied asylum between 2012 and 2017. Yet in April 2017, Cleveland immigration judge Alison Brown granted Damus asylum. ICE made the rare decision to appeal Damus' asylum grant and kept him in jail while the case was considered by the Board of Immigration Appeals, a division of the Justice Department. The appeals board sided with ICE and ordered Brown to reconsider parts of her decision. She granted

Damus asylum for the second time in January 2018. ICE appealed again. Damus had now been in jail for 14 months, and there was no end in sight. Damus compared his experience to showing up at someone's home and asking for help. America let him in and then treated him like a robber, he said.

ICE has long detained more people than its detention centers can hold, but under Trump, the number of detainees has shot up to record highs. ICE has let far fewer asylum-seekers out of detention, while also targeting long-settled undocumented immigrants who spend more time in detention because they have strong cases for remaining in the United States and are less likely to be deported quickly. As a result, it has expanded its capacity at both dedicated immigration detention centers and local jails it pays to hold immigrants. The Geauga County jail gets $70 per day per immigrant from ICE, or more than $25,000 per year, according to ICE records from 2017. The average number of immigrants at the jail more than doubled between 2014 and 2018, from 28 to 76 in a facility with a total capacity of 182. Nationally, ICE held roughly 14,500 migrants at more than 170 city and county jails in 2018—more than a third of the agency's inmates. All across the country were people like Damus who'd followed the legal procedures to seek asylum and ended up isolated in jail cells in places where they'd never planned to be.

Ford, working pro bono, put together a second parole application after Damus was awarded asylum a second time in January and ICE again appealed. She tried to head off ICE's claim that Damus lacked community ties by getting a local family to offer to house him. Through Anne Hill, an immigration activist, Ford got in touch with Hart and Benjamin. They immediately agreed to sponsor Damus, even though they had never met him. "We are empty nesters and have a large home," they wrote in a letter to ICE, in which they listed their professional qualifications: Benjamin was a lawyer and Hart was an accountant.

Later that month, Damus heard an announcement over the jail's intercom: "Damus visit." He thought it was a mistake and didn't respond. Then he heard it again. He went over to the monitors and saw what he described as two white faces. He couldn't communicate much with Hart and Benjamin during that first visit. He barely spoke English, and Benjamin knew only rudimentary French, but they eventually found ways to understand each other. Hart and Benjamin wrote Damus three letters a week in French, with the help of Google Translate, and mapped out uplifting conversations in advance of their weekly Sunday visits. Damus was often on the verge of giving up and voluntarily allowing himself to be deported back to Haiti. Their goal was to keep him fighting. Chantal Dothey, a doctor who had moved to Ohio from Belgium, visited him on Friday nights after hearing about his case from Hill.


Dear sponsor,

It's with a real pleasure I am writing this letter to express my feelings and gratitude toward you because of the attention I receive. I think you are God's messenger to help and support me in this situation. I was really happy when I received your mail the last day.

An excerpt of a letter Damus sent to Benjamin and Hart with the help of a fellow migrant at the jail.

ICE policy requires the agency to assess each parole request individually and consider the facts of the case. ICE denied Damus' parole request one day after Ford sent in the paperwork, even though he'd been granted asylum and ICE's appeal was pending. Government data later showed that ICE's Detroit field office, which covers Ohio, denied almost every asylum-seeker's parole application in the first months of the Trump administration. This was happening across the country, in a trend that started in the Obama administration but accelerated dramatically under Trump. In five field offices including Detroit, the average rate of parole approvals dropped from 92 percent between 2011 and 2013 to less than 4 percent between February and September 2017, even though ICE claimed its parole policy had not changed.

In early February, Damus met with Freda Levenson, the legal director for the American Civil Liberties Union of Ohio, about a potential lawsuit. Along with Damus' charm and character, Levenson was struck by the food he was served. "It was this pallid, pale, indistinguishable, undefinable gunk with this thin mush over it," she said.

"He did everything according to the law," Levenson later said. "Every single thing right. The person that broke the law here was the government. He was the innocent party." In March, the ACLU, Human Rights First, and the Center for Gender and Refugee Studies filed a class-action lawsuit challenging ICE's blanket parole denials, with Damus as the named plaintiff.

"I have not been outside for more than a year," Damus said in a March court declaration. "I have not even glimpsed natural light. I have not breathed fresh air or felt the sun on my face, and I never know if it is cold or hot outside, if the sun is out, and if the seasons are changing." Since his detention, Damus said, he had been "unbearably sad, uncomfortable and totally lacking in privacy."

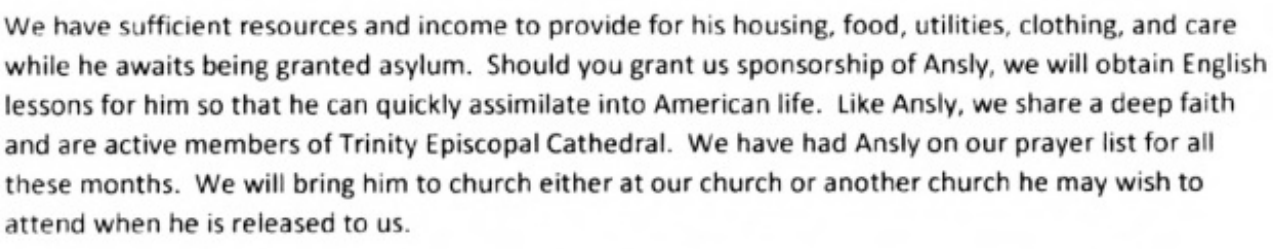
Damus' case applies specifically to asylum-seekers who enter the United States legally. Currently, asylum-seekers who enter the United States without authorization have an easier path to getting out of confinement. They can be granted bond by immigration judges, who

are generally more willing to release them than ICE, which makes the determination for people who come to official ports of entry. The Justice Department is expected to announce a change imminently that will require all immigrants to get parole from ICE, which would place all asylum-seekers in Damus' position.

As Damus' cases inched forward, Hart and Benjamin contrived an improbable line of communication between Damus and his family in Haiti. Their bishop got in touch with his church's national headquarters and learned of an upcoming trip to Haiti. Damus wrote a letter to his wife, Adeline, and a church member hand-delivered it. A slightlysimpler process emerged after Dothey found Damus' wife on Facebook. Damus wrote letters and mailed them to Hart, who scanned and emailed them to Adeline. Hart would then print and mail the response to Damus. She saved Damus' original letters in the hopes of giving them to him if he got out.

The jail didn't allow Damus to make international calls, but Coralie Saint-Louis, a volunteer interpreter for the nonprofit Institute for Justice and Democracy in Haiti, made it possible by having Damus call her and patching him through to his wife back home. Hart and Benjamin tried to give Damus books in French, but the jail said donations for individual inmates were not allowed. They settled on photocopying books and mailing them 20 pages at a time, the maximum length for a letter. Damus asked for a French version of Karl Marx's *Das Kapital*.

Damus' best hope of being released came over the summer, when the federal judge hearing the class-action case ruled that ICE had to follow its parole guidelines and give due consideration to each application. Ford put together a third parole application, this time with letters from a dozen community members including a local judge, a city councilwoman, and clergy. ICE sent an official to meet with Damus, then denied him parole a third time. Ford didn't hesitate when asked if ICE had made a good-faith effort to evaluate Damus' request. "Oh, no, they're not seriously considering this," she told me, adding, "That's ridiculous."


We have sufficient resources and income to provide for his housing, food, utilities, clothing, and care while he awaits being granted asylum. Should you grant us sponsorship of Ansly, we will obtain English lessons for him so that he can quickly assimilate into American life. Like Ansly, we share a deep faith and are active members of Trinity Episcopal Cathedral. We have had Ansly on our prayer list for all these months. We will bring him to church either at our church or another church he may wish to attend when he is released to us.

An excerpt of Benjamin and Hart's second letter to ICE offering to sponsor Damus.

The ACLU focuses on forcing systemic changes and rarely takes individual cases. It made an exception for Damus. Two ACLU attorneys demanded Damus' release in a September letter to ICE and made clear that he was willing to wear an ankle monitor. After ICE ignored the

letter, the ACLU brought a lawsuit to demand that a federal judge release Damus. It was the first time Ford had ever had such a lawsuit filed on behalf of one of her clients, and she thought it was a longshot.

Then came another setback: Brown, the immigration judge, denied Damus asylum at his third hearing after the Board of Immigration Appeals overturned his second asylum grant. Now Damus was the one who had to appeal. But he had lost hope and planned to go back to Haiti. Saint-Louis, who provided moral support along with language interpretation, persuaded him to keep going. After the call with her, he cried.

Damus had grown wary of life in the United States when we first spoke in October. Back in Haiti, an American doctor had told him the United States needed professionals like him, and he took it to heart. Now he said that if he were ever released, he would be afraid of Americans he encountered in the outside world. One of his cellmates had problems with drugs and frequently talked in his sleep. “It’s inexplicable, it’s unacceptable, and intolerable,” Damus said about his incarceration. He felt that the years he had lost to jail were his biggest failure in life.

Outside the jail, Hart, Benjamin, and dozens of Ohioans, who called themselves Ansly’s Army, were protesting ICE’s decision to keep Damus incarcerated. They held rallies and prayer vigils with ministers outside ICE’s Cleveland office on Thursdays, on one occasion attracting nearly 60 people. The police once observed them with a German Shepherd in tow, though there was no need for it. “We’re all geriatrics,” Benjamin joked. Each person carried a different letter of a sign that read “Free Ansly.”

Later in October, Dothey drove out past the strip malls and country roads that lead to the Geauga County jail. As usual, she slid her ID under a two-way mirror and told an invisible official she was there to visit Damus. Inside the visitation room, Damus’ features were washed out on the monitor beneath a webcam encased in the beige plastic of outdated electronics, although his striped prison uniform was clearly visible. Damus did most of the talking, in French, while Dothey listened. She was his first visitor since he had reached two years of incarceration earlier that week. “Two years in the US,” he told me dejectedly in English. “Two years in the US.” He added that he felt bad all the time these days. His hearing in the ACLU’s suit to get him released was still three months away, and there was little to look forward to. The screen flashed off for a second to warn that the visit was almost over. One minute later, it read, “No Signal.”

Two days after Dothey’s visit, Hart and Benjamin were tabling in support of Damus at church. Hart told a church group about a meeting of Ansly’s Army later that day and then headed to the jail to visit Damus. The meeting of his supporters took place at Hart and Benjamin’s Cleveland Heights home, a seven-bedroom 1915 Tudor. Molly Brudnick, a 82-year-old retired social worker, captured the mood in the room. “No matter what we do,” she said, “no matter what the ACLU does, no matter what his attorney does, we still have Ansly

in jail for no reason other than the absolute power of ICE." Most of the half-dozen people in the room had not been involved in immigration activism before Trump took office. The meeting pointed to what may be one of Trump's most lasting and unintentional legacies: an organized progressive base attuned to the injustices of modern immigration enforcement.

The next day, a federal judge moved up Damus' January hearing to November 28. The judge, Judith Levy, ordered that Damus appear at the hearing. The government asked if a video conference would suffice, but Levy responded that no, he would need to come in person. Damus would be wearing civilian clothes for the first time since getting to the border. Levenson, the ACLU attorney, was feeling increasingly optimistic. But Ford, who had been with Damus through all his disappointments, thought there was no way Levy would rule in Damus' favor.

The empty room Benjamin and Hart kept ready for Damus.
Noah Lanard

On November 28, Hart, Benjamin, and about 30 others piled onto a chartered bus for the three-hour drive from Cleveland Heights to the federal courthouse in Ann Arbor, Michigan. Damus showed up in the courtroom shackled at the legs, and Levy immediately ordered that the shackles be removed. During a recess, Hart and Benjamin hugged Damus for the first time. Levy decided she needed more information to make a ruling and ordered a follow-up call the next day. Damus spent the night in jail in Detroit. He couldn't sleep and decided that if the court declined to release him, he would give up and go back to Haiti.

Before the call, the government told the ACLU it was willing to settle. It would release Damus if he agreed to wear an ankle monitor and live with his sponsors, the same conditions the ACLU and Damus had agreed to in September. Ford got a call from an ICE officer asking her to arrange for someone to pick up Damus at the Cleveland ICE office in one hour. She called Hart and Benjamin. "Call me when he's in the car," she told them. "When you have him in the car, then I'll know it's true."

Last Friday, 768 days after he was first detained, Damus walked out of the Cleveland ICE office as a free man. He wore a dark suit and a white shirt buttoned to the top without a tie, and he beamed. "I want go to church," Damus told reporters in English. "Tell God, 'Thank you.' He give me my life." That night, Damus and Ansly's Army celebrated at the Hart-Benjamin house with steak and champagne. On Saturday, Hart and Benjamin got him set up with a phone, email address, and a library card. Sunday was church—two masses and many more hugs—and a tour of downtown Cleveland. And throughout it all, many calls

home. Since leaving for Brazil, Damus had missed his son's first, second, third, and fourth birthdays. Had ICE not appealed his asylum grant, he would have already been able to apply for his family to join him in the United States.

Damus speaks to members of Ansly's Army at the party celebrating his release.
Courtesy of Benjamin and Hart

Damus had his first quiet morning on Tuesday. He'd been surprised to see how often Americans eat in restaurants and was still looking forward to a home-cooked Haitian meal of rice, beans, and chicken. He was happier and more spirited than I'd ever heard him.

But his prospects are still daunting. Now that he is out of detention, his case will likely be a lower priority for the Board of Immigration Appeals. Hart and Benjamin have been told to be prepared to have Damus living with them for two years. The Board of Immigration Appeals has ruled against him twice, and there is reason to believe it will do so again. That would force him either to appeal to a federal court or to accept deportation.

But after so much hardship, everyone is enjoying a rare period of respite, even if it is mixed with the sadness of knowing that Damus lost two years of his life. "When you think about it, it's just kind of sick that we can be happy about this," Levenson said. "Because it's misery ending."

Unlike so many people who have been incarcerated by ICE, Damus is still in America. He plans to put his experience in jail to good use. On Tuesday, he spoke to an immigrant advocacy group about his time in Geauga County. He had received cards from the group but thought they came from an individual and expected to talk to one person. When he arrived and saw the night's program, he was surprised to find that he was speaking to a crowd of about 30. As at every turn in his saga, he had more support behind him than he could have foreseen.

Damus at a dinner at Hart's son's home after his release from jail. Courtesy of Benjamin and Hart

Exhibit G

March 21, 2020 Letter from Bd. of Correction of the City of New York to Criminal Justice Leaders

BOARD OF CORRECTION
CITY OF NEW YORK
1 CENTRE STREET, RM 2213
NEW YORK, NY 10007
212 669-7900 (Office)
212 669-7980 (Fax)

March 21, 2020

Darcel Clark
Bronx District Attorney

Eric Gonzalez
Brooklyn District Attorney

Melinda Katz
Queens District Attorney

Michael McMahon
Staten Island District Attorney

Cyrus Vance
Manhattan District Attorney

Janet DiFiore
Chief Judge of the Court of Appeals and of the State of New York

Anthony Annucci
Acting Commissioner, NYS Department of Corrections and Community Supervision

Cynthia Brann
Commissioner, NYC Department of Correction

VIA EMAIL

Dear New York City's Criminal Justice Leaders:

The New York City jails are facing a crisis as COVID-19 continues its march through the City. We write to urge you to act to (1) immediately remove from jail all people at high risk of dying of COVID-19 infection and (2) rapidly decrease the jail population.

Staff of the Department of Correction (DOC) and Correctional Health Services (CHS) are doing heroic work to keep people in custody and staff safe and healthy. The Board of Correction, the independent oversight agency for the City's jails, has closely monitored Rikers Island and the borough jails for over sixty years. From this experience, we know that DOC's and CHS's best efforts will not be enough to prevent viral transmission in the jails. Their work must be supplemented by bold and urgent action from the City's District Attorneys, New York State judges, New York State Department of Corrections and Community Supervision (DOCCS), and DOC's utilization of its executive release authority. Fewer people in the jails will save lives and minimize transmission among people in custody as well as staff. Failure to drastically reduce the jail population threatens to overwhelm the City jails' healthcare system as well its basic operations.

Over the past six days, we have learned that at least twelve DOC employees, five CHS employees, and twenty-one people in custody have tested positive for the virus. There are more than 58 individuals currently being monitored in the contagious disease and quarantine units (up from 26 people on March 17). It is likely these people have been in hundreds of housing areas and common areas over recent weeks and have been in close contact with many other people in custody and staff. Given the nature of jails (e.g. dense housing areas and structural barriers to social distancing, hygiene, and sanitation), the number of patients diagnosed with COVID-19 is certain to rise exponentially. The best path forward to protecting the community of people housed and working in the jails is to rapidly decrease the number of people housed and working in them.

Mayor de Blasio announced on March 19 that the NYPD and Mayor's Office of Criminal Justice (MOCJ) had identified 40 people for release from custody, pending approval of the District Attorneys' Offices and the courts. This number is far from sufficient to protect against the rapid spread of coronavirus in the jails.

We urge you to follow your colleagues in Los Angeles County (CA), San Francisco (CA), Cook County (IL), Autauga County (AL), Augusta County (VA), Allegheny County (PA), Hamilton County (OH), Harris County (TX), Travis County (TX), and Cuyahoga County (OH), and take action now to release people from City jails. As further detailed below, this immediate reduction should prioritize the release of people who are at higher risk from infection such as those over 50 or with underlying health conditions. Additionally, you must safely release other people in jail to decrease the overall population; this process should begin with people detained for administrative reasons (including failure to appear and parole violations) and people serving "City Sentences" (sentences of one year or less). The process should continue to identify all other people who can be released. DOC and CHS should provide discharge planning to all people you release, including COVID screening, connection to health and mental health services, and support with housing, as necessary.

People over 50 years old

The morbidity rates for COVID-19 accelerate with age, with older people being the least likely to recover from complications of the virus. There are currently 906 people in DOC custody who are over age 50. Older adults in custody have an average of between three and four medical diagnoses each, and each of them takes between six and seven medications. Of the 906 older adults in custody today, 189 are being detained on technical parole violations. Another 74 older adults are City-Sentenced, serving one year or less for low-level offenses.

People with underlying health conditions

People with underlying health conditions, including lung disease, heart disease, diabetes, cancer, or a weakened immune system, are especially at risk of dying from COVID-19. As of today, there are 62 people in the infirmary at North Infirmary Command on Rikers Island. They are housed there because they require a higher level of medical care. Twelve of them are technical parole violators and six are City-Sentenced. In addition, there are eight women currently in the infirmary at the Rose M. Singer Center, three of whom are in custody on technical parole violations.

People detained for administrative reasons
There are currently 666 people in custody being held solely for a technical violation of parole, including failure to make curfew, missing a meeting with a parole officer, or testing positive for drugs. There are an additional 811 people detained on an open case and a technical parole violation who also should be reviewed for immediate release.

People serving city sentences
There are currently 551 people in DOC custody who are serving a City Sentence of under one year for low-level offenses. The Mayor must use his executive powers to release these people.

New York must replicate the bold and urgent action it has taken in other areas to stem the tide of COVID-19 in the jails. The Board strongly urges you to take urgent action today to drastically reduce the NYC jail population using the guidelines above.

Sincerely,

Jacqueline Sherman
Interim Chair

Exhibit H

March 23, 2020 Linh Ta, Iowa's Prisons Will Accelerate Release of Approved Inmates to Mitigate COVID-19, Times Republican

Times-Republican

Iowa's prisons will accelerate release of approved inmates to mitigate COVID-19

Contributed photo Anamosa State Penitentiary is a maximum-security prison in Jones County.

From school districts to workplaces to restaurants, Iowans across the state are shutting their doors and keeping to themselves to mitigate the spread of COVID-19. But for inmates in Iowa's jail and prisons, social distancing is not an option.

The close quarters and transient influx of new people behind bars creates a precarious situation where a highly contagious virus like COVID-19 could spread and expose not only inmates but also the general public.

To mitigate a possible outbreak and create more room in Iowa's overcrowded prisons, the Iowa Department of Corrections plans to expedite the release of about 700 inmates who were already determined eligible for release by the Iowa Board of Parole.

"We're trying to be more efficient in our area and free up some space," said Beth Skinner, director of the Iowa Department of Corrections.

By accelerating the release wait list, more beds will open up, which can allow the correctional facility to move inmates more easily if an outbreak does occur in a prison. Iowa's eight prisons are already about 23% overcrowded, according to the Iowa Department of Corrections daily statistics.

Skinner

But releasing people without offering them a place to go doesn't help either, Skinner said. She said they're working to ensure all parolees have a place to stay once they return to their communities.

"It has to be a suitable, safe place," Skinner said.

Prisoners medically screened before intake or release

Beyond accelerating the release of people, the Iowa Department of Corrections is also medically screening all new inmates and people who are released from their facilities, Skinner said.

On average, 500 new inmates are transferred to the prisons on a monthly basis, Skinner said.

Correctional workers will take their temperatures and give them medical questionnaires to fill out. Because symptoms of COVID-19 may not immediately show, new inmates are automatically quarantined for 14 days.

Visitations are also temporarily suspended to mitigate the spread of COVID-19, but the department is examining reducing the costs of mail and phone calls, Skinner said.

Inmates and correctional officers have access to soap and water and employees are also provided hand sanitizer.

A *"huge piece"* in preventing outbreaks will be COVID-19 tests, however, Skinner said. Each correctional facility will receive five to six tests, which can help them evaluate people who may have symptoms and quarantine them.

"We get the people who have the flu. What's different with this one is the unknown," Skinner said.

ACLU: Iowa should do more to reduce prison population

But an Iowa civil rights group believes the state should go even further to reduce the density of the prison population and mitigate the spread of COVID-19.

ACLU of Iowa is calling for comprehensive changes to law enforcement and correctional facilities practices.

Veronica Fowler, spokesperson for ACLU of Iowa, said limiting arrests and releasing more people not only protects the jail and prison populations, but also the general public who may be exposed to COVID-19 by a correctional officer.

"We have in any one day about 16,000 people, essentially behind bars," Fowler said of Iowa's prisons and jails. *"That is the equivalent of Clive or Boone or Oskaloosa. We're not talking about tiny little populations."*

The organization is calling for limiting the number of arrests, people in county jails and number of people being held on pretrial detention. Additionally, the group is asking the state to commute people with medical conditions who would have been released in the next two years and commuting people who were scheduled to be released in a year.

Another concern is an order from the Iowa Supreme Court, Fowler said.

On March 14, the Iowa Supreme Court ordered all criminal jury trials be postponed until April 20. Fowler said that could result in some inmates staying behind bars longer than necessary.

Fowler said ACLU plans to send a letter to the governor and state officials detailing their requests.

"If all these people get sick, that's a health crisis that overwhelms the system," Fowler said.

In Johnson County, 37 inmates were being held in the county jail. The county has the highest rate of COVID-19 with 22 confirmed cases so far. The facility was originally built to house 46 inmates, but by double-bunking inmates, it can hold 92, according to The Gazette.

No plans for early release from expanded Polk County jail

At the Polk County Jail, there are no plans to expedite the release of prisoners, said Lt. Heath Osberg of the Polk County Sheriff's Office.

In 2008, Polk County finished construction on a new jail facility that holds 1,500 inmate beds and is tripled in size from the previous jail.

Because of the larger size, Osberg, said there is not overcrowding in the jail. Around 749 inmates were being held in the jail as of Friday afternoon.

The difference between jails and prisons, however, is the more transient flow of people coming in and out.

Between Wednesday and Thursday, 24 inmates were booked into Polk County Jail, according to its website. Eleven of those detained have already been released.

Osberg said inmates who are brought into the facility are getting their temperatures checked and filling out medical questionnaires.

He said any changes in the release of inmates would have to come from county attorneys and Iowa courts.

Fowler said she hopes state officials stay aware of Iowa's jailed population, particularly people who can't afford to pay bond and those with health conditions that make them more vulnerable to COVID-19.

"The bottom line is that we already have an over-incarceration problem in our country and our state," Fowler said.

Exhibit I

March 19, 2020 Release Ohio Jail Inmates Vulnerable to Coronavirus, Chief Justice Urges, WLWT5

Release Ohio jail inmates vulnerable to coronavirus, chief justice urges

wlwt.com/article/release-ohio-jail-inmates-vulnerable-to-coronavirus-chief-justice-urges/31788560

March 19, 2020

Updated: 4:03 PM EDT Mar 19, 2020

Hide Transcript Show Transcript

Thank you. Thank you. Thank you very much. Governor. Thank you for the invitation to participate this afternoon. I want to thank you also for your courageous leadership on this subject. I think that you have set Ohio as an example for the rest of the nation, and we're proud. This is an unprecedented time, undoubtedly a time when, during during which the judiciary of Ohio as well as the bar, the state and local leaders must come together to guarantee the vital and continued operation of the state's judicial system and the public's access to justice. I both command and thank Ohio's judiciary for taking action, issuing orders and considering the health and safety of the public as well as their staff, all the while mindful of the structure and dictates of our Constitution and our laws. My intent today is to let everyone know what the courts are doing and my expectation of what they should be doing to continue operating in a manner consistent with the state's public health strategy. Last Friday, I met with the state's state judicial leadership to discuss the judiciary is response to this pandemic. After that meeting, I sent a lengthy email to all judges in Ohio. In the meeting and email, I emphasize several key points that I want to highlight today. Courts must open must be open to address emergency and time sensitive matters. Indiscriminate closure of the courts with no plan for these issues is not an option. Judges across each county must cooperate among themselves to issue orders and established procedures necessary to continue essential court functions. In this rapidly developing situation and in light of the further directives of Governor DeWine and health officials, the need for uniform by in and consistency among judges is paramount. Further, judges need to consult and collaborate with local leaders to develop a plan to ensure essential access to the courts that it will continue this collaborative. This collaboration needs to include all stakeholders, clerks of court, health and law enforcement officials, attorneys, treatment providers, Children service's and others. These air, all essential members of the operation, total closure of the courts and the clerks of court offices presents an access to justice issue. Measures can be taken to ensure access to justice while safeguarding the health of employees. By limiting but not eliminating access, the courts could be closed to the public for non essential purposes. I've asked judges to prioritize their workload to reduce the need for jury pools in the level of public traffic in courthouses. I encourage them to maximize technology and to modify their orders to reduce the need for face to face interaction. I urged them to consider lowering bonds and using summons instead of arrest to help minimize jail populations. I noted some

creative local solutions to these problems and urge courts to use their authority and their initiative to employ similar solutions. Courts all over the state have responded by issuing orders that do just that. I might add that the website of the Ohio Judicial Conference, which can be accessed from our website s si dot Ohio dot gov that's s si dot Ohio dot gov, contains the orders issued by the local courts. If you access it, you will note the response by our judiciary. For example, courts and que Haga County have suspended all non time sensitive civil and criminal jury tile trials, and they've implemented a jury call and system, so the jurors would not have to appear unnecessarily. Also, when possible hearings are being conducted by video to reduce person to person contact foreclosure actions and sheriff sales are stayed for 60 days. This will ensure that individuals are not forced out of their home during the public health crisis. Jackson County has leveraged their existing statutory authority under the Ohio revised Code to extend speedy trial time in criminal cases on the grounds of the governor's emergency declaration. As I've advised Ohio revised code 29 45.72 states the time within which and accused may be brought to trial or in the case of a felony to play Maneri. Hearing and trial may be extended during the period by any for the period of any continuance granted on the accused own motion and the period of any reasonable continuance granted other than upon the accused own motion. This allows for continuances upon reasonable grounds. Judges can and should employ that provisioned where appropriate and issue orders detail ing the reasonable grounds for the continuance. And Franklin County Municipal Court has authorized the use of Rick Cognisant bonds for nonviolent misdemeanors and traffic cases. But there's still more work to be done today. I want to encourage local courts to continue using their own authority and initiative toe address common issues that we see across the state. For example, I urge all judges to grant continuances or use alternate methods for non essential court appearances. Ensure that the clerk's office remains open and are accessible to the public. Temporarily stay appropriate evictions and foreclosure proceedings. Temporarily refrain from issuing warrants for failure to appear for traffic violations. Minor misdemeanor and nonviolent misdemeanor offenses. Find ways to provide remote and yet meaningful treatment options for those with substance abuse disorder change, probation and community control, and pretrial supervision meetings to phone or video reporting. Finally, I urge judges to use their discretion to release people held in jail and release incarcerated individuals who are in a high risk category for being infected with the virus. Looking ahead, we will be working with the governor and the General Assembly on a legislative proposal which will provide more uniformity and continuity in our judicial system's response to emergencies such as this. I must also mention the work of the Supreme Court staff itself. We continue to consider and decide cases, although we have taken common sense measures consistent with the governor's guidance to reduce risk, the court remains open. We have a central staff performing their duties on an off site. We will continue to accept case filings, provides support for judges, for local court staff and for attorneys. Finally, I understand that many local courts lack the technology and resource is needed to implement many of these suggestions. To meet that demand, the Supreme Court will release funds in the form of

grants to local courts to obtain video conferencing equipment. It is my hope that by pushing out this funding on an emergency basis, we can assist the local courts in a quick implementation of video conferencing, four arraignments and other conferencing needs. I expect to announce the process for those grants tomorrow. We decided on an amount of $4 million that will be taken from my budget and dispersed to the local courts for this purpose. Now, before I take your questions, I'd like to say that I have personally been in touch with many judges. The bar association's leadership and in constant conversation with the director of the Ohio Judicial Conference, Paul Peiffer, were working together in this ever changing environment, and we are so pleased to continue to do so. Thank you. Now I will take any questions that you might have. Kevin Landers, W B. N S 10 TV Can you explain a little bit more about releasing prisoners who are in the high risk category of attracting the virus? Thank you. There obviously are many different ages and health conditions of prisoners in our jails. And a new assessment should be done to determine whether or not they can safely be released, given the fact of their age and maybe other health conditions that they might have that they have to deal with. This is two fold one Thio Safeguard the, uh, the folks that are in jail and also to offer the individual who may be at risk the opportunity to be isolated outside of the jail environment. This is up to the local courts to do this is and in conjunction, obviously with the sheriffs who run the jails. But this is something that I've asked them to consider. Hi, Chief Justice, This is Molly Martinez with spectrum news. I'm wondering if there's any push to sort of clear out low level offenders and sort of make more room in the prisons during this pandemic. Well, I don't speak for the prisons. I'm talking about the jails. When I make this recommendation, Will there be any leniency with the jails and who is incarcerated? Well, that's what I mentioned, that the judges should review their bail on the the circumstances by which they have people detained in the jails and prioritize releases based on that. Thank you, Chief Jin Province with its little blade. There were two justices who have recused themselves from the Election Day lawsuit. Could you tell us how you're going to replace them in considering this case? And if you can kid you comment on the fact that you yourself are being sued over your Election Day morning decision? Well, first of all, I'm not gonna comment on pending cases. I will tell you in general, when cases air not Orly argued, there is no need for a visiting judge to sit on a case. We need four justices to create a majority. As you well know on as long as we have four justices that are in unison, there's no need to deal with the fact that we don't have four justices. If we did have a problem with four justices that would be in agreement, then there would be a need to supplement with visiting judges. But not at this time. Thank you. I chief I under Welch Huggins with The Associated Press. In terms of the recommendations that you've made that you'd like to see judges and courts undertake, Um, can you explain whether you have the ability to ramp that up at all on bacon? Actual judicial order on depending on your answer to that? Is that something that you would take advantage of? In other words, instead of making recommendations? Do you have any way to issue a directive on order two judges to actually do these things? Um, thanks for that question. You know, there's two different types of judicial systems in the 50 states that we have in our country. One is called a unified system,

and one is what we have here in Ohio, which is a non unified system in the unified systems. The Supreme Court chief justice has that type of power that you just described and can issue directives not just for emergency situations, but many other situations that present themselves In the course of managing, you know, the judicial system in the state. We don't have that in Ohio. We have superintendents Rule 14 which is a deck licked declaration of a judicial emergency. This does not go as far as what you were suggesting. That there would be a pronouncement from the chief justice that would be binding on all judges. At least that's my interpretation of Row 14 at this time, when I mentioned that we are looking at legislation, that's exactly what we're looking at to create legislation that would under very, very limited and specialized circumstances, such as what we are experiencing here. Should there be a need, the opportunity for the chief justice to make those type of orders that would be binding on the judiciary real quickly. The Legislature is actually meeting next week. Are you looking at a fixed that quickly when you're talking about that type of legislation? In an ideal world, that's the way it would happen. But we're not in an ideal world, so we'll see. Thanks, Chief Justice's Jake's Ackerman from though How Capital Journal. I wouldn't ask about your decision against any moratorium on infections. Is it prudent to allow the eviction process to continue in this pandemic? Would you repeat your question? I thought I heard you say that there was no moratorium on evictions. Could you clarify that for one? And is it prudent to continue to allow the eviction process to continue in this pandemic? That's an interesting question. Most people think that evictions are just for mirror nonpayment of your rent or whatever the situation. But there are certain types of evictions that maybe, for example, domestic violence on and trying to get someone evicted from the home because they present a danger to the other members of the living in that home. So it's up to the courts to be to deal with that and to figure out yes, if there is an eviction that is in process or going to, they could have a moratorium on filing of evictions and foreclosures in the same way they could do that. But then again, they have tohave the flexibility that if someone needs to be removed through the eviction process because they're a domestic violence perpetrator, that should be allowable on a local court's judgment and their initiative. So, you know, Ohio has 88 different counties, over 700 judges over 350 courts in this state on, and we are not, as I said, a unified state. But there's a reason. I think, maybe for that it's because we have such a such a variety of communities on court systems and resource is. So I am in favor of the solutions coming from the locals and being implemented by the local courts and local community leaders and officials. Of course, Andi, as a last resort, I would resort to, uh, you know, the contents of the legislation that I just described now different mayors in the state that I'm aware of have urged that evictions be stayed, that any utilities be reinstated or the process to, you know, terminate be suspended on those are those air good practices and those air practices that I definitely would urge. Thank you. Hello, Chief Justice Polt easily with Hannah. I'm told I'm your last question today. Apparently, Hamilton County Judge he can has asked you to issue a uniform order uniformed guidance in keeping with your power to quote, do all things necessary to ensure the orderly and efficient administration of justice and then related to that. Can you speak to any equal protection

concerns for potential jurors or witnesses in different counties under varying Kobe 19 orders to appear or not appear in court. Okay, would you repeat what the judge from Hamilton County would? For what purpose? Oh, uh, you know, based on a Cleveland dot com. Our article. Apparently they're quoting him. He is asking you to issue a uniform order for all courts based on your power quote to do all things necessary to ensure the orderly and efficient administration of justice. In other words, that would be your legal authority to do so. Now, I know you've addressed Ohio being non uniform. I didn't hear you address that precise phrase. I don't know where it appears right now. And then they're related question again. What equal protection concerns are there for jurors and witnesses in different counties under different covert 19 orders. Okay, if there was a need, if our local judges and local leadership we're not addressing Theo issues that presented themselves, maybe I would have to take a look at intervening in some way. But that's not the case that we have here today. There is, uh, you know, as I said, there's orders you can take a look at them on the website, and you can see for yourself the type of measures that are being taken in the individuals courts. And there's many, many, many of these measures that are taken in the courts to address this, and they address all kinds of situations. Primarily, they're concerned about jury pools, which points to your second question, Um, and not having jury trials because of the health risk that that imposes the fact that you may have difficulty even having jurors report. So if the court employs the appropriate statutory authority to continue cases, there's where your authority is. And that's how those those trials can be continued. Yes. And as the state's chief legal mind, as it were, can you address the equal protection question between counties? Okay, well, I'm not gonna address an equal protection question. First of all, there's not one before us, and secondly, if there was, I'd have to consult with my colleagues because it would be a case in front of us. And I don't speculate on cases, either when they're being filed or when they're potentially so. With that, if there are no other questions, thank you very much. Next

Updated: 4:03 PM EDT Mar 19, 2020

Ohio Chief Justice Maureen O'Connor is urging Ohio jails to release inmates vulnerable to the COVID-19 coronavirus.During a Thursday afternoon news conference alongside Gov. Mike DeWine, O'Connor made several recommendations to curb the spread of the new coronavirus.Among them was releasing some inmates in the state's jails.O'Connor said the benefit would be twofold, safeguarding other inmates currently incarcerated in Ohio's jails, as well as allowing the at-risk inmates be isolated outside of the jail environment.O'Connor added it is just a recommendation, and is up to the individual courts to decide."I'm urging judges to use their discretion and release people held in jail and incarcerated individuals who are in a high-risk category for being infected with the virus," she said.WATCH HER FULL COMMENTS IN THE VIDEO PLAYER ABOVEAn assessment should be done on each individual, she said, taking into account age

and health condition.The chief justice also said courts should be closed for nonessential purposes, adding that shuttering them entirely is not an appropriate measure. Courts should remain open to address emergency and time-sensitive matters, she said.O'Connor also urged courts to lower bonds to decrease individual jail populations. She's also pushing to delay eviction proceedings and to issue continuances when possible.During Wednesday's news conference, officials announced that there were 119 confirmed cases across the state. Those cases have been reported in the following counties: Ashland (1), Belmont (2), Butler (8), Clark (1), Coshocton (2), Cuyahoga (53), Darke (1), Delaware (2), Franklin (10), Geauga (1), Hamilton (1), Huron (1), Lake (2), Lorain (6), Lucas (1), Mahoning (5), Medina (5), Miami (1), Montgomery (1), Richland (1), Stark (5), Summit (6), Trumbull (2) and Tuscarawas (1).

COLUMBUS, Ohio —
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WATCH HER FULL COMMENTS IN THE VIDEO PLAYER ABOVE

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Exhibit J

April 1, 2020 Adam Ferrise, Coronavirus Got 900 Inmates Out of Cuyahoga County's Troubled Jail When Inmate Deaths Didn't. Some Say the Changes Should Stick

Coronavirus got 900 inmates out of Cuyahoga County's troubled jail when inmate deaths didn't. Some say the changes should stick

cleveland.com/court-justice/2020/04/coronavirus-got-900-inmates-out-of-cuyahoga-countys-troubled-jail-when-inmate-deaths-didnt-some-say-the-changes-should-stick.html

By Adam Ferrise, cleveland.com

April 1, 2020

CLEVELAND, Ohio — A record rate of deaths at the Cuyahoga County Jail couldn't spark officials to work together to empty the crowded jail. Nor could a four-year effort at bail reform, criminal and civil rights investigations into the jail, and cries for help from corrections officers and judges in reigning in crisis after crisis at the jail.

The coronavirus pandemic did in about three weeks.

At its peak in 2018, during a period where eight inmates died in six months, the jail housed about 2,500 inmates when it was supposed to hold a maximum of 1,765. From March 9 through Tuesday, when coronavirus fears hit home, the jail shed about 900 inmates and now houses 1,065.

The coronavirus pandemic sparked changes that criminal justice reform advocates sought for years. The swift action taken by Cuyahoga County officials in the weeks since the pandemic hit Ohio showed that those reforms could have come sooner, some county officials said. It also provides a roadmap of how the changes could continue.

“Where we are right now is where we should have been all along,” Cleveland Municipal Judge Mike Nelson said. “The way they expedited hearings and taking hard looks at the cases— we should have been there all along.”

Officials ramped up their effort dramatically after a March 10 meeting with prosecutors and Cuyahoga County Common Pleas judges. They set the meeting previously to discuss how judges could expedite their dockets with the looming pandemic. MetroHealth Dr. Julia Bruner, who oversees healthcare at the jail, asked to speak to the judges during the meeting.

Bruner laid bare the potential for disaster if officials were unprepared for a case of coronavirus in the jail. She told the judges that, as coronavirus spreads, it could impact 30 percent of jail staff, spread through the jail quickly and leave officials with too few workers and too many inmates to treat.

“From that point on in the discussion, there was very little resistance in the room,” Bruner said. “[Administrative] Judge Brendan Sheehan did a good job talking this over with everyone.”

The next day, the NBA suspended its season, underscoring the gravity of the challenge ahead. It was clear to the Cuyahoga County Jail officials and the county’s judges that the nature of the jail makes social distancing measures next to impossible.

The highly contagious virus could pass to inmates and workers in short order, causing staff shortages and a crush of new coronavirus cases that would burden hospitals already gearing up for lack of space, beds and equipment.

Ohio Gov. Mike DeWine also issued an order on March 16 that said the state’s prisons could reject inmates sentenced to prison if they’ve been held in a county jail where inmates have tested positive for COVID-19.

Cuyahoga County Sheriff David Schilling issued a directive to all judges and police departments in the county March 12 telling them they could reject anyone sentenced to jail time on misdemeanors — unless it was for domestic violence or a sex crime. He also urged all police departments to consider issuing summons instead of arrests except for people who pose a serious public risk.

Those orders cut the number of new inmates booked at the jail from about 85 per day to 30, Bruner said.

Jail officials implemented plans to screen all incoming inmates and employees for symptoms of coronavirus. Brunner compiled a list of 325 of the most at-risk inmates, including the elderly and those suffering from serious illnesses, and sent the list to the judges and prosecutors so they could review the cases.

Sheehan on March 16 declared a judicial emergency and suspended nearly all courthouse business, including hearings for people who are free on bond in criminal cases and almost all civil proceedings. That allowed judges to focus almost solely on getting inmates out of jail, he said.

County prosecutors, judges and defense attorneys convened a specialized Saturday docket on March 14 to hear cases of people in the jail on low-level felonies. The following week saw other judges dedicate their time to similar cases.

As inmates were released, jail officials ensured they had access to prescriptions and linked them with social services, Bruner said. Jail officials shuffled remaining inmates around to clear two floors in the jail for inmates who need to be quarantined or isolated for the virus' seemingly inevitable arrival.

As of Tuesday, no inmates have tested positive, Cuyahoga County spokeswoman Mary Louise Madigan said.

"Facing this pandemic, everyone brought a sense of urgency to this issue that something had to be done immediately or there would be tragic consequences," Cuyahoga County Prosecutor Michael O'Malley said.

Sheehan, who took over the administrative and presiding judge position in January, several months after the last death at the county jail, struggled to understand why the deaths of several inmates did not create the same sense of urgency among county and court officials as the pandemic.

"In the present, I can say we're dealing with it and everyone's hands are on deck," Sheehan said.

Attempts fail for years

The Cuyahoga County Jail in downown Cleveland.

Activists for years pointed to issues showing that those accused of non-violent, low-level offenses had no reason to be in jail. Being in the jail created a burden that they sometimes were unable to overcome, including the loss of jobs or losing custody of their children.

Reform efforts started in earnest in 2015 when Cuyahoga County followed other state's efforts at taking a hard look at the ethics and consequences of keeping people accused of low-level, non-violent crimes behind bars solely because they couldn't afford the pay bail.

County officials convened two different task forces aimed at first studying and then implementing bail reform across the county. Studies, monthly meetings with public comment did little to move the dial forward throughout the county, though some judges took steps on their own.

Jail officials, meanwhile, took on an effort to consolidate the county's various jails under the county government's umbrella. Cleveland agreed, but moving inmates out of the old city jail only contributed to the problem at the county jail, which lacked the beds to accommodate new prisoners and the staff to watch them. At the same time, jail officials sought to cut basic costs for food and supplies for inmates and medical employees at the jail.

The influx of inmates led to a practice known in corrections as "red-zoning," where guards relegate inmates to their jail pods for about 23 hours out of the day. Red-zoning is a practice done at jails that lack the proper amount of staff to oversee a considerable inmate population.

As the Cuyahoga County Jail population ballooned in 2018, inmates died at a rate never before seen in the county. Eight died between June and December 2018, and a ninth died in May 2019. Five took their own lives.

The deaths prompted investigations by the U.S. Marshals, the FBI and Ohio Attorney General. The U.S. Marshals issued a report that detailed "inhumane" conditions and potential civil rights violations.

The attorney general's office launched a criminal probe that has so far obtained convictions in several cases where jail officers beat inmates. The jail's former warden pleaded guilty to crimes, and the old jail director faces criminal charges.

Officials made some changes, including the hiring of more corrections officers and more nurses. The county allowed MetroHealth to take over all healthcare at the jail. Cuyahoga County Executive Armond Budish hired Bill Mason, the former county prosecutor, to push judges to hold mass bail hearings reduce the jail's population, but that plan ultimately stalled.

That effort led judges and prosecutors to look more closely at inmates' cases, which helped lower the population to between 1,800 and 1,900 on most days. But none of the efforts ever led to widespread reform.

Then coronavirus hit.

"It's been a tremendously coordinated effort," said Cuyahoga County Public Defender Mark Stanton, whose office represents some of the poorest criminal suspects in the community. "It should be a foundation for authentic bail reform. A good percentage should have never been in there in the first place. It's going to have to be the foundation moving forward."

Moving forward

The changes already had positive effects on the jail, Bruner said. Because they freed inmates with serious ailments, medical officials can focus on those who remain and provide better care. She also said they're seeing fewer requests for inmates to be sent to hospitals for treatment of more severe and chronic illnesses.

The question that lingers is, will the changes made in the last three weeks continue when the pandemic has waned? Some believe it will, while others cautioned that it would be more difficult once the courthouse reopens for regular business.

When restrictions due to coronavirus lift, and judges resume all of those other court hearings, it would be unrealistic to expect the current trend to continue, Sheehan said.

But Sheehan agreed that officials should not let the jail return to its previous condition, and said he has a few ideas to bring up when the time comes.

"I think once we're done with this crisis and we look back at it, there are some good changes we can make to the way our jail is handled," Sheehan said.

Jail population numbers are fluid and depend in part on local police arresting people. Schilling, the sheriff, left his order on refusing to house misdemeanor sentences open-ended.

“It forced us all to take a hard look at it,” O’Malley said. “It clearly shows what can be done when you put your mind to it.”

O’Malley said he plans on asking the judges if they could set monthly hearings to focus solely on cases where an inmate is jailed on non-violent offenses. The goal would be to keep people they can release on bond or would be amenable to a plea deal from slipping through the cracks.

“Post-pandemic, we have to make certain that the jail is there to hold people accused of violent felonies to protect the community and we have to work toward getting others into treatment programs and prevent recidivism,” O’Malley said. “I think what we’re seeing now is that it’s holding people exclusively for violent felonies, which is what it should be there for.”

Stanton, the public defender, said he was surprised when the death toll at the jail failed to push along the notion of bail reform. But he said he believes some judges and others in the justice system have permanently come around to the idea of bail reform because of the coronavirus.

“It’s somewhat tragic that we had to have a pandemic to nudge people to think like this,” Stanton said. “I didn’t want bail reform to be instituted on the back of a pandemic. That, to me, is also inherently immoral. But I do believe that in Cuyahoga County, there is an evolution of a change in attitude.”

Cleveland.com reporter Cory Shaffer contributed to this story.

Read more from cleveland.com:

Will wearing a mask protect me from coronavirus? The answers aren’t that simple

Coronavirus deaths rise to 8 in suburban Cuyahoga County; 9 countywide

Why are different coronavirus models predicting a wide range of outcomes in Ohio?

Exhibit K

March 22, 2020 John Sandweg, I Used to Run ICE. We Need to Release the Nonviolent Detainees, The Atlantic

IDEAS

I Used to Run ICE. We Need to Release the Nonviolent Detainees.

It's the only way to protect detention facilities and the people in them from COVID-19.

MARCH 22, 2020

John Sandweg
Former acting director of Immigration and Customs Enforcement

CHRIS CARLSON / AP IMAGES

With more than 37,000 detainees closely confined in facilities across the country, Immigration and Customs Enforcement (ICE) detention centers are extremely susceptible to outbreaks of infectious diseases. The design of these facilities requires inmates to remain in close contact with one another—the opposite of the social distancing now recommended for stopping the spread of the lethal coronavirus.

Read: What you need to know about the coronavirus

As the former Acting Director of ICE under President Obama, I know that preventing the virus from being introduced into these facilities is impossible. This week, the Trump administration announced that, in light of its concern that the virus could be introduced into detention centers, it

would shift its enforcement operations to focus only on criminals and dangerous individuals. This means that the agency will arrest and place in detention only those undocumented immigrants who have serious criminal convictions. Those without a criminal record will be allowed to stay at home as they go through the deportation process. This is a necessary and crucial first step, but the administration must do more: It must release the thousands of nonviolent, low-flight-risk detainees currently in ICE custody.

ICE is fortunate that the threat posed by these detention centers can be mitigated rather easily. By releasing from custody the thousands of detainees who pose no threat to public safety and do not constitute an unmanageable flight risk, ICE can reduce the overcrowding of its detention centers, and thus make them safer, while also putting fewer people at risk.

This doesn't mean that dangerous criminals will be walking the streets. Those who threaten Americans' safety can and must continue to be detained. However, the immigration detention system is not designed to detain only those who have committed serious crimes or pose a significant flight risk. In fact, only a small percentage of those in ICE detention have been convicted of a violent crime. Many have never even been charged with a criminal offense. ICE can quickly reduce the detained population without endangering our communities.

Read: How Trump radicalized ICE

The large-scale release of detainees doesn't mean that undocumented immigrants should get a free pass either. Those who are released can and should continue to go through the deportation process. ICE can employ electronic monitoring and other tools to ensure their appearance at mandated hearings and remove them from the country when appropriate.

When an outbreak of COVID-19 occurs in an ICE facility, the detainees won't be the only ones at risk. An outbreak will expose the hundreds of ICE agents and officers, medical personnel, contract workers, and others who work in these facilities to the virus. Once exposed, many of them will unknowingly take the virus home to their family and community. Moreover, once the virus tears through a detention center, crucial and limited medical resources will need to be diverted to treat those infected. ICE can, and must, reduce the risk it poses to so many people, and the most effective way to do so is to drastically reduce the number of people it is currently holding.

We want to hear what you think about this article. Submit a letter to the editor or write to letters@theatlantic.com.

Exhibit L

March 16, 2020 Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff

South Carolina
JUDICIAL BRANCH

Court News ...

The Supreme Court of South Carolina

DONALD W. BEATTY
CHIEF JUSTICE

POST OFFICE BOX 3543
SPARTANBURG, SOUTH CAROLINA 29304-3543

MEMORANDUM

TO: Magistrates, Municipal Judges, and Summary Court Staff

FROM: Chief Justice Beatty

RE: Coronavirus

DATE: March 16, 2020

As the number of coronavirus cases has increased in South Carolina, and a state of emergency has been declared, the South Carolina Judicial Branch continues to consider all aspects of court operations.

As the situation continues to develop, we will provide further information and direction if and when circumstances so warrant. In the meantime, please review the following directives for your courts.

- All jury trials are postponed. Non-jury trials and other hearings may continue to be held, but only attorneys, their clients, and necessary witnesses will be allowed to appear.
- All roll calls and any other large gatherings such as traffic court are cancelled until further notice.
- If you deem it necessary to curtail operations beyond the scope of this memorandum, courthouses should remain available for the following critical functions:
    - Acceptance of filings and payments (including bonds)
    - Emergency hearings (including, but not limited to: restraining orders, orders of protection, bond revocation/modification, and vacating of bench warrants)
    - Transmission of necessary information to SLED and/or NCIC
    - Compliance with the Financial Accounting Order
- Any person charged with a non-capital crime shall be ordered released pending trial on his own recognizance without surety, unless an unreasonable danger to the community will result or the accused is an extreme flight risk.
- Bench warrants for failure to appear shall not be issued at this time.
- At a minimum, bond hearings should be held at least once per day.
    - The court shall continue to conduct probable cause determinations if a defendant is arrested and incarcerated on a Uniform Traffic Ticket.
    - The bond court shall continue to unseal bench warrants, or inform defendants of right to counsel and new court dates, and vacate bench warrants.
    - Victim's rights must be upheld. A victim advocate/notifier must be available for bond hearings.
    - If a defendant has been in jail as a pre-trial detainee for the maximum possible sentence, the court shall convert the bond to a personal recognizance bond and release the defendant.
- Court dates may be rescheduled as is necessary and prudent.
- To the extent possible and circumstances warrant, hearings that can be held by video may be held remotely. Telephonic hearings may be held remotely as a last resort.
- Counties/municipalities with orders in place whereby the Chief Magistrate may appoint magistrates to serve as municipal judges should do so as necessary if the current municipal judge(s) becomes unable to hold court.
- If a magistrates court temporarily closes, there should be adequate signs posted directing persons to the nearest other magistrates court(s) within the county where filings and payments may be tendered. The court should include this information on its voicemail and website/social media if possible.
- The courts must maintain a 24-hour judge on-call schedule and provide it to jails and law enforcement. Amend the schedule as necessary.

The SCJB's Crisis Management Team will continue to monitor this situation and provide further information as received. We remain committed to the safety of the state court system and to the public. Thank you for your assistance in implementing these measures.

DECLARATION OF CORRYLEE DROZDA

(pursuant to 28 U.S.C. §1746)

My name is Corrylee Drozda, and I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, I declare the following:

1. I am an attorney at the Legal Aid Society of Cleveland (Cleveland Legal Aid) and have been admitted to the Ohio Bar. My attorney number is 0095958. I have been an attorney with Cleveland Legal Aid since October 2018 and I practice within our Immigration Group.

2. The Legal Aid Society of Cleveland is a nonprofit law firm that secures justice and resolves fundamental problems for those who are low income and vulnerable by providing high quality legal services. We have four offices throughout the Greater Cleveland area to serve our client communities in Ashtabula, Cuyahoga, Geauga, Lake, and Lorain counties.

3. One of the vulnerable populations we serve are immigrant victims and survivors of crime and violence. We represent clients in their removal proceedings before the Cleveland Immigration Court and in their applications before U.S. Citizenship and Immigration Services (USCIS).

4. In the fall of 2018, Cleveland Legal Aid formed a partnership with Cleveland Catholic Charities to provide Know Your Rights (KYR) presentations to immigrants who are detained under ICE custody at local jails during their removal proceedings before the Cleveland Immigration Court. Since then, we have provided legal advice, *pro se* assistance, or full representation to nearly 40 individuals in civil immigration detention.

5. We began providing KYR presentations to immigrant detainees at the Geauga County Jail in early 2019. Prior to the COVID-19 pandemic, Cleveland Legal Aid and Catholic Charities visited the jail every other Wednesday to conduct a KYR presentation, answer attendees' questions, and then conduct intakes with attendees who did not yet have attorneys to determine if we could assist with their cases. Our last KYR presentation was on March 4, 2020. Since then, I have frequently spoken with my clients but have been unable to see them in person. For the last two weeks I have spoken with clients in Geauga almost daily. My last conversation with a client was today.

6. Through my regular participation in the KYR presentations, meetings with clients who are being detained by ICE in the Geauga County Jail, and conversations with clients' family members, I am familiar with the facility and the conditions of confinement to which the people we serve are subject.

7. I estimate that I have visited the Geauga County Jail at least 20 times during the past year. My most recent visit was on March 4, 2020 during which I co-led the KYR presentation and subsequent intakes with a Catholic Charities attorney.

8. I currently have three clients who are detained at Geauga and I regularly speak to them about their cases and the current conditions within the jail.

9. Based on my own experience with the general conditions at the jail from observing the areas to which I have had access (which includes the entrance, the multi-purpose rooms, and a side meeting room), as well as what I regularly learn from my currently detained clients, I have an understanding of the physical layout, operations, and conditions in the jail.

Conditions in the Geauga County Jail

10. When you enter the Geauga County Jail, there is a tiled waiting room with plastic chairs, an opaque-glass window to the left behind which several sheriff's deputies sit, and a secured double door straight ahead through which you enter the detention area. To enter the detention area, you must speak to a deputy through a small hole in the window and then wait for a deputy to escort you through the two sets of doors. The deputy escorts you through the first door, inspects you, and asks you to sign in. Then, the deputy escorts you through a second set of doors.

11. Inside, there are several gray cement, windowless hallways blocked off with heavy doors that must be opened remotely once the door behind you is secure. Once the door opens, a deputy escorts you down a hallway that leads to three multi-purpose rooms, where we hold the KYR presentations and where we meet individually with clients. There are no windows to the outdoors in any of the internal rooms I have personally seen.

12. Off this main hallway that leads to the multi-purpose rooms, there are sex-segregated cement dormitories or "pods." I personally have not toured the dormitory portions of the facility; therefore, my knowledge of the pods is based on my clients' descriptions of them.

13. According to a female client, her pod holds 10 women, including herself. The pod consists of a common area with communal tables, televisions, and showers. It does not have any windows that open to the outside. Around the common area are small rooms where the detainees sleep and use the bathroom. Most of the rooms within the pod are for two people, though one or two rooms are for an individual.

The double rooms contain just enough room for two beds, one toilet, one sink, one small desk, and two lockers. While my client said she has a hard time with specific space estimates, she is sure the beds are closer together than six feet. There is no privacy around the toilet and within the room it is not possible to social distance from your roommate.

14. The women are free to leave their rooms to use the common area of the pod whenever they choose, but since the COVID-19 pandemic, they can only leave their pods for approximately 30 minutes each day to go to the library. They are not permitted to go outside. It does not seem that any other social distancing measures have been implemented. Even with this limitation on detainees' movements within the larger facility, based on my understanding of the pod structure, it is not possible for detainees to socially distance themselves from one another.

15. The women in their pod eat all their meals at the communal tables in the common area of the pod. There are not enough tables to eat their meals at a safe social distance from one another.

16. According to clients there have been no changes to cleaning or sanitation procedures since the COVID-19 pandemic. I have heard from both male and female clients that they must purchase their own soap and shampoo from the commissary. The only soap the jail provides to detainees free of charge is a small bottle of liquid soap that only lasts for a couple days. To obtain the liquid soap, a detainee must call the commissary to request it and can only request one bottle at a time. Soap is delivered to the pods on Wednesdays and Saturdays only.

17. Paper towels are not available to the detainees. One client told me that the only towel they have to dry their hands after washing them is the same towel they use to dry off after showering. These towels are washed on Tuesdays and Fridays. Likewise, detainees have two sets of uniforms—the one they are currently wearing and one extra. The used uniform is washed on Tuesdays and Fridays.

18. As before the COVID-19 pandemic, detainees are responsible for cleaning their pod each day. They have not been given any instructions for enhanced cleaning procedures. Each day, a jail staff member brings them a cart with water, a bucket, a green cleaning solution, a mop, and rags to wipe down the tables. They have not been given any extra supplies.

19. According to a client, jail staff just started wearing masks on April 8. Only some staff members wear gloves. The detainees have not been provided with any masks or gloves.

20. I have not heard from any clients who are aware of any testing taking place. If someone needs medical attention, they must write a "kite," or a note, to the medical staff and then wait for a response. Typically it takes two or three days for the staff to respond to their medical needs.

21. Through speaking with my clients, I sense that there is a lot of confusion and fear around COVID-19 in part because the jail staff has not been transparent about what efforts the jail is taking to protect detainees' health and safety. Most of the information detainees have received about COVID-19 is through the news they listen to on the television. They have not received any updates about the jail's response to the pandemic.

22. The immigrant detainees being held at the jail under ICE custody are particularly vulnerable to confusion and misinformation because they are limited English proficient. I have observed through my numerous visits to the jail that minimal efforts are made to provide interpretation or translation of English documents to detainees whose primary language is not English. Additionally, it is my understanding that an ICE officer visits the jail only once every two weeks to communicate with the immigrant detainees and that the ICE officer only speaks English. Other than these brief and infrequent visits, ICE officers are not available to answer immigrant detainees' questions or respond to their concerns.

Dated: April 10, 2020

I sign this under penalty of perjury.

/s/ Corrylee Drozda /KF
Corrylee Drozda

DECLARATION OF JULIE BURNETT

(pursuant to 28 U.S.C. §1746)

My name is Julie Burnett, and I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, I declare the following:

1. I am a legal assistant at the International Institute of Akron.

2. The International Institute of Akron (IIA) is a nonprofit working to provide a range of services to immigrants and refugees in the Northeast Ohio area. We provide services including resettlement, employment and housing support, translation, legal assistance, and other direct assistance. We serve clients from all over the world and in many situations, including those in detention.

3. I have worked with IIA as the legal assistant since January 2019. My duties include interpreting and being a point of contact for Spanish speaking clients and prospective clients, fielding calls from individuals detained by ICE who reach out to our office, managing case files, and assisting attorneys in communicating with detained clients, completing immigration forms, and other legal work. I am the main point of daily contact for our clients and prospective clients.

4. In this role, I have spoken with dozens of people detained by ICE in the Seneca and Geauga County Jails, the main detention facilities in our service region. Because people in detention are sometimes moved around the state, I have also spoken to clients and others in the Butler and Morrow County Jails, and formerly, in the Northeast Ohio Correctional Center. I have an understanding of what the people we serve experience in ICE detention.

5. We currently represent two people who ICE is holding in the Seneca County Jail. I speak to these clients daily by phone, and I also speak frequently with many other people in that facility who are seeking legal advice or referrals. Very often, when one person is on the phone with me, they will pass the phone to someone else who is having an issue, or who just wants to talk to someone outside of the jail. Other times, people call us looking for representation or other services. Over the past few months, I have spoken to more than a dozen ICE detainees at Seneca, and at least someone on a daily basis.

6. Since the spread of COVID-19 hit Ohio several weeks ago, people have been calling us more frequently, from and about the jail. People I hear from are very afraid, and they are usually seeking help, release, or medical information.

7. Based on my recent conversations with our clients and others detained there, I have an understanding of what people are currently experiencing at the Seneca County Jail, and how the conditions there have devolved during the spread of COVID-19.

Conditions in the Seneca County Jail

8. At Seneca County Jail, all detainees are confined to several "pods": concrete, dormitory-style rooms where an entire group of people eats, sleeps, and has all of their recreation time together. Each pod contains this one congregate space and one shared bathroom.

9. Our two current clients are detained in the same pod. There are about 35 men total in this pod; 26 are detained by ICE and the other 9 are U.S. citizens. There is also one other, similar pod, and I also regularly speak to people detained there.

10. Everyone in the pod sleeps in small bunk beds, with a few feet between the top and bottom bunk, and a few feet between each bed. This means that each person is considerably less than 6 feet from multiple other people each night when they sleep.

11. There are also several tables nearby to each other, where everyone eats together at meal times. This also the area where people spend their time during the day.

12. Everyone eats, sleeps, and lives in this same space; there is nowhere else to go.

13. Detainees at Seneca are rarely provided with hygiene materials, other than two soap dispensers in the shared bathroom, which often run out and are rarely refilled. Besides this, detainees are required to purchase their own soap, shampoo, and other basic necessities from the commissary. No hand sanitizer is available.

14. Detainees can only wash their clothes once every three days, and they have only one spare pair of clothes. They also only have one towel each, which they must use to dry off after showers and to dry their hands after washing them. They can also only wash this towel once every three days. There are no paper towels or air-dryers in the bathroom.

15. About 6 weeks ago, the jail was “locked down” as a result of the COVID-19 pandemic. Some U.S. Citizen prisoners were released. Attorneys, chaplains, social workers, and others stopped visiting the facility. However, staff continue to come in and out.

16. Moreover, no procedures have changed inside the jail: no distancing, cleaning, or hygiene measures have been put into place, and given the setup, distancing would be impossible. The food preparation and medical access are the same. Staff at the

jail use gloves but no one I have spoken to has yet seen them wear masks. Detainees have not been provided any information about the disease, its spread, or what might happen to them as a result of it. Tests are not available to them.

17. Once daily, someone from the jail staff wipes off the tables and phones in the pods. Since before the lock-down, and continuing through when I am writing this, no staff have ever cleaned the bathroom in the pod. Detainees must pay for basic soap and shampoo, if they are able to afford it with their own money, from commissary to clean the bathroom themselves. Similarly, if they want any other cleaning to be done anywhere in the pod, detainees must do this themselves with their own personal hygiene products.

18. About 5 people I have spoken to within the last week told me they have symptoms that include coughing, sore throats, and headaches. They have all submitted requests for medical assistance and have not received any type of medical attention, medication, or testing for COVID-19.

19. Yesterday, I spoke to a client who had such a hoarse throat from coughing that it was difficult for me to understand him. He was very afraid that he had contracted COVID-19, and that he would not be able to get medical help.

20. It has always been difficult for the people I speak with to access medical services because of delays in accessing treatment, and it has become even more difficult within the past few weeks.

21. One person detained in this pod has had a toe infection that makes it hard for him to walk. He has been submitted requests to medical for weeks and has not received any type of medical attention.

22. Two people detained in this pod have reported extreme pain in their molars, and they similarly have not received any medical attention.

23. There is a universal understanding among the detainees that when you tell medical staff you are sick, they say they will return for an appointment, but never return. This was the case prior to the COVID-19 outbreak, and it is still the case.

24. The people I speak to are fearful of other jail staff, who make racist and other disparaging remarks towards them. Recently, two people have told me that when they try to go to the bathroom at night, guards yell and swear at them.

25. Everyone I have spoken to since the jail was locked down is terrified that they are already sick, or will become sick, from COVID-19. Without having been given any information or supplies, they are confused about what they can do to take any safety measures at all.

26. This information is what I know as of April 8, 2020. On April 9 and 10, I tried to get in touch with detainees at Seneca like I usually do, and I did not receive any calls back, or detainee-initiated calls. I had a scheduled phone appointment on April 10 with a prospective client there who never called. This is highly unusual, and I am very worried.

Dated: April 10, 2020

I sign this under penalty of perjury.

Julie Burnett