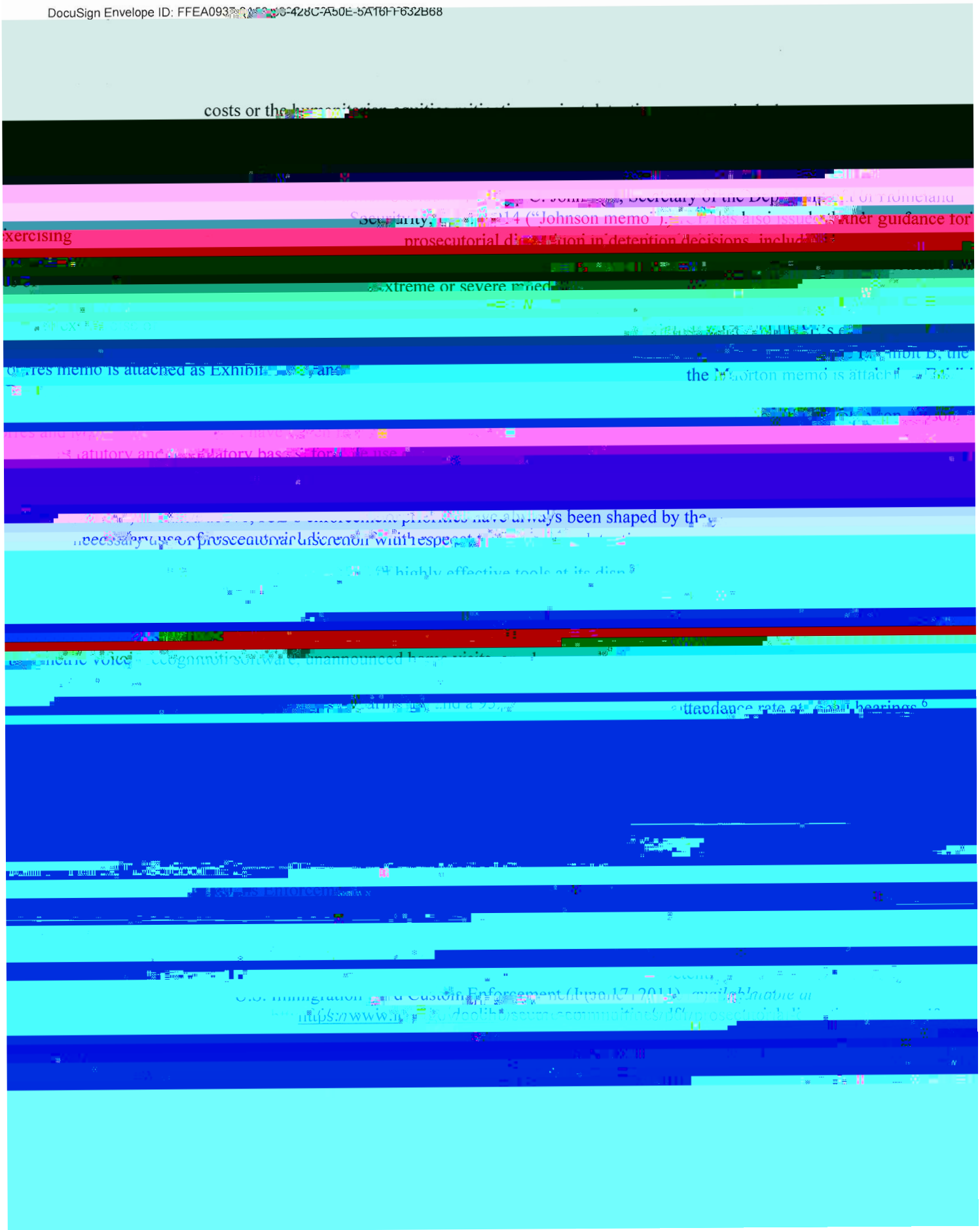

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT, et al.,

Plaintiffs,

v.

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

Defendants.

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

Declaration of Anne Rios in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

DECLARATION OF ANNE RIOS

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

1. My name is Anne Rios. I am a licensed attorney in good standing, in the state of California. I have been practicing law since 2009. I am a supervising attorney with the nonprofit organization Al Otro Lado (AOL). I have represented over 75 detainees in release efforts; approximately 35% of those detainees are medically vulnerable.

2. AOL is a legal services organization that serves indigent migrants, refugees, deportees, (a)9.1(5(nd)701)9.1(5(n/0)8.5(i)8.2.1( )]Ti.2(te)3.6(s ot(a)12.1m)4.2

12. Teleconferencing creates a challenge for AOL to advocate for its clients to protect them against COVID-19, especially medically vulnerable clients. For instance, there are no accommodations made for clients who are hearing impaired, who have mobility issues, or who speak rare languages.

AOL Clients Expressed Increased Anxiety Due to the COVID-19 Pandemic

13.

was quarantined. Most of those who are quarantined are “low levels”, mean

23. It appears that the overall cleaning routine remains the same as it was prior to

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**Pro Hac Vice Application Forthcoming

Declaration of Dr. Carlos Franco-Paredes

properly accommodate the needs of patients should there be an outbreak of COVID-19 in an immigration detention facility. The physical and emotional trauma that detainees and asylum seekers experience can weaken their immune systems, resulting in increased risk of severe manifestations of infections. For example cases of influenza virus infections causing pneumonia and respiratory failure, albeit influenza infection is not as communicable and not transmitted during asymptomatic infection as it is the case with SARS-CoV-2, has caused human deaths inside immigration detention centers.

- For people in the highest risk populations, the fatality rate of COVID-19 infection is about 15 percent.

According to the CDC, groups deemed to be at high risk of developing severe disease and dying from COVID-19 include those above 55 years of age and those with underlying medical conditions (regardless of their age) (See Table 1). These cases are also amplifiers or hyper-spreaders of the infection since they tend to have high viral concentrations in their respiratory secretions.

The clinical experience in China, South Korea, Italy and Spain has shown that 80% of confirmed cases tend to occur in persons 30-69 years of age regardless of whether they had underlying medical conditions. Of these, 20% develop severe clinical manifestations or become critically ill. Among those with severe clinical manifestations, regardless of their age or underlying medical conditions, the virus progresses into respiratory failure, septic shock, and multiorgan dysfunction requiring intensive care support including the use of mechanical ventilator support. The overall case fatality rate is 1.4% of those who develop severe disease. In China, 80% of deaths occurred among adults > 60 years.

Table 1. Risk factors for developing severe disease and death outside the U.S.

Age groups at high risk of developing severe disease and dying without underlying medical

conditions	
Groups with underlying medical conditions at high risk of dying regardless of their age	-Cardiovascular Disease (congestive heartfailure, history of myocardial infarction, history of cardiac surgery) -Systemic Arterial Hypertension (high blood pressure) -Chronic Respiratory Disease (asthma, chronic obstructive pulmonary disease including chronic y di(a)12.1 3 (n 6p112.1 (tnTc - 4 ( )0Cj EM(e)3.5[(te)12.1 (n)8.31 (m)4.th(ic)3.6 Chrseisey ofy3 (n 6p112.1 (tn)]T3.6t (l H)8.1(e)1

There is a growing number of confirmed cases in the U.S., increasing number of hospitalizations and admissions to intensive care units, and many

team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians. This level of support can quickly exceed local health care resources.

There is sufficient evidence that the SARS-CoV-2 pandemic has an overwhelming impact in healthcare utilization in all settings (China, South Korea, Italy, France, Germany, and others). In the U.S., current evidence demonstrates that COVID-19 cI3.7 (e)3.6 (a)3 in (I3.7 (e)3.6.5 (i)8.4 (ng)8.2 p (S)4.4 004 Tc -0.6 (r)3.

potential community-based impact of an outbreak inside immigration detention centers. Therefore, it is my professional view that releasing detainees/asylum seekers on humanitarian parole from these centers constitutes a high-yield public health intervention that may significantly lessen the impact of this outbreak not only within detention centers but among the communities surrounding these centers. In particular, targeting the release of persons in the age groups at risk of severe disease and death; and persons with underlying medical conditions, may lessen the human and financial costs that this outbreak may eventually impose on ICE detention facilities nationwide. Responding to an outbreak requires significant

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

FAOUR ABDALLAH FRAIHAT, et al.,

Plaintiffs,

v.

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

Defendants.

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

Declaration of Elissa Steglich in Support of Motion for Preliminary Injunction and Class Certification

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**Pro Hac Vice Application Forthcoming

DECLARATION OF ELISSA STEGLICH

[redacted]

families before the immigration courts, Board of Immigration Appeals, federal courts and U.S. Citizenship and Immigration Services.

[redacted]

witnessed or were made aware of. They were scared and concerned, recognizing that

[redacted]

8. Based on our conversations, no additional supplies of soap have been made available

Two individuals rep

quality available. No hand sanitizer or dispenser

e reported any significant changes in cleaning the dorms and other areas of the

y.

observed three of the court rooms functioning as normal. Social distancing

9. No on

facilit

10. I also

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

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

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

Defendants.

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

DECLARATION OF HOMER VENTERS IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION AND CLASS CERTIFICATION

Date: March 24, 2020

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**Pro Hac Vice Application Forthcoming

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

Background

1. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with ICE on numerous individual cases of medical release, formulation of health related policies as well as testimony before U.S. Congress regarding mortality inside ICE detention facilities.
2. After my fellowship training, I became the Deputy Medical Director of the NYC Jail Correctional Health Service. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and

s well as all trainin training he13.9j, addiction, quality improveenta,re -ntary and morbidity and

published in early 2019 by Johns Hopkins University Press. A copy of my curriculum vitae is attached to this report which includes my publications, a listing of cases in which I have been involved and a statement of my compensation.

COVID-19 in ICE Detention

5. Coronavirus disease of 2019 (COVID-19) is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.

6. COVID-19 infection rates are growing exponentially in the U.S. The outbreak curve is in the early stages, meaning that communities are beginning to see their first cases, and that the number of cases overall is rising rapidly, with doubling times between one and three days. The Governor of California predicted that over half of all residents will become infected with COVID-19 and the Commissioner of Health for New Jersey predicted, "I'm definitely going to get it, we all will."[1] The Centers for Disease Control (CDC) now reports COVID-19 cases in all 50 states.

7. ICE will not be able to stop the entry of COVID-19 into ICE facilities, and the reality is that the infection is likely inside multiple facilities already. When COVID-19 impacts a community, it will also impact the detention facilities. In

[1]

New Jersey, one employee at an ICE detention facility has already tested positive,[2] and this is likely just the tip of the iceberg in terms of the number of ICE staff that are already infected but

In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become useless, and even when in good working order, may impede their ability talk and be understood, in the case of masks. For officers working in or around patients at risk with symptoms, there may be an effort to have them wear protective gowns, as we would in any other setting with similar clinical risks. These gowns cover their radios, cut down tools and other equipment located on their belts and my experience working with correctional staff, are basically impossible to use as a correctional officer.

10. Efforts to lock detained people into cells will worsen, not improve this facility-level contribution to infection control. When people are locked into cells alone, for most of the day, they quickly experience psychological distress that manifests in self-harm and suicidality, which requires rapid response and intensive care outside the facility for mental and physical health emergencies. In addition, units that are comprised of locked cells require additional staff to escort people to and from their cells for showers and other encounters, and medical, pharmacy and nursing staff move on and off these units daily to assess the

pulmonary disease.[4] In correctional settings, the age of 55 is used to identify older patients, because of the extremely high level of physical and behavioral health problems among this cohort of people.[5] I believe the age of 55 should be applied to ICE detainees for the same reason.

14. On the whole, ICE's response to the COVID-19 pandemic is lacking. I've reviewed available documents with the

to protect them. The protocol also fails to address the identification of high-risk patients who have already been admitted. This is a dangerous omission, because many of the ICE facilities employ paper medical records, and identification of the people who meet criteria for being high risk of serious illness and death from COVID-19 will require significant time and staffing. I have led these types of risk reviews in outbreaks using both electronic and paper based medical records in multiple correctional settings, and there must be a clear direction and protocol for how this process will occur and how often it is repeated, and how critical information will flow from health to security staff. The protocol focuses on whether patients have contact with known COVID-19 patients and whether they are symptomatic. It is true that symptomatic patients require higher levels of assessment and care, but a basic element of outbreak management is protection of patients who, if they become infected, are at high risk of serious illness or death. The ICE protocol faw [(high risk of se4 Tc .037

staff, and asking staff to rely on their historical knowledge of influenza treatment without precise guidance on the critical decisions regarding COVID-19 testing, treatment and hospital transfer will lead them and their patients without clear guidelines. These deficiencies, compounded by the time it will take to evaluate and transport them to a local hospital (especially given the remoteness of many facilities), will likely result in numerous deaths, many of which could have been avoided with earlier care.

16. The ICE response, including the protocol, envisions that "isolation rooms" will be used to monitor people who are symptomatic with COVID-19. My experience in visiting and working in detention facilities across the nation is that each facility has 1-4 cells located in or near the medical clinic that meet this definition. When COVID-19 arrives in a facility, there will be many more people who meet this criteria of being symptomatic, and ICE will need to designate entire housing areas for this level of increased surveillance of symptomatic patients. This approach requires that empty housing areas be available, so that small numbers of symptomatic patients can be cohorted together away from those without symptoms. Facilities that are over 80 percent capacity will find this basic approach impossible once they start to see multiple symptomatic patients. Based on my experience visiting detention facilities, this process will be essentially impossible.

17. ICE should not employ isolation in locked cells as a primary means to protect either at risk patients, or patients who are symptomatic. When patients are places into locked cells, the level of monitoring is dramatically reduced. In addition, this practice causes new and additional problems in the form of risk for suicide and self-harm. Also, isolation units often drive cost.

the most basic infection control policies that they report as their standard of care including:

a. Failure to provide hand washing supplies including soap and paper towels and ensure access to handwashing, including operable sinks;

b. Failure to check symptoms among newly arrived detained people;

c. Continued transfer among detention centers of detained people;

d. Lack of symptom screening of staff arriving to work in detention centers;

e. Failure to ask about risk factors of serious illness or death from COVID-19 infection;

f. Failure to provide adequate supplies for cleaning of housing areas;

g. Failure to establish standards of use of gloves and masks by security personnel;

h. Failure to provide patient education about hand washing, infection control or COVID-19 in Spanish;

i. Failure to enact social distancing among staff and detained people; and

j. Lack of communication regarding COVID-19 status inside quarantined housing areas.

21. I have also reviewed the declarations of all the named subclass members and agree their medical conditions place them at high-risk and make them medically vulnerable to COVID-19.

22. ICE's inadequate responses to COVID-19—coupled with its pre-existing inadequate healthcare—places people with risk factors at a high risk of contracting COVID-19 and suffering serious complications—including death.

23.

Signature: Homer Venters

Date: 3/24/2020

&9)*#*5 "

Dr. Homer D. Venters
10 ½ Jefferson St., Port Washington, NY, 11050

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from for-profit staffing company model to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009
Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.
Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University 7/2004- 5/2007.
M.D., University of Illinois, Urbana, 12/2003.
M.S. Biology, University of Illinois, Urbana, 6/03.
B.A. International Relations, Tufts University, Medford, MA, 1989

Peer Reviewed Publications

Parmar PK, Leigh J, Venters H

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. Int J Env Res Public Health. 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, Homer Venters. Meaningful Use of an Electronic Health Record in the NYC Jail System. Am J Public Health. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Ahuja, Homer Venters. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. Am J Public Health. 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Allison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, Homer Venters. The Rikers Island Hot Spotters. Am J Public Health. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonald, Homer Venters. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. Bulletin of the World Health Organization. 2015

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathanial Dickey, Homer Venters. Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System. J Health Care Poor Underserved. 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, Venters H. Data-Driven Human Rights: Using Dual Loyalty Training to Promote the Care of Vulnerable Patients in Jail. Health and Human Rights. Online ahead of print, 3/12/15.

Teixeira PA[1], Jordan AO, Zaller N, Shah D, Venters H. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. Am J Public Health. 2014 Dec 18.

Selling D, Lee D, Solimo A, Venters H. A Road Not Taken: Substance Abuse Programming in the New York City Jail System. J. Correct Health Care. 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, Venters H. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. Am J Public Health. 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, Venters H. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. Health and Human Rights. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, Venters H. Case series of exercise-induced [illegible] 0 Tm 0 Tc 0 Tw (1)Trh62LF0 1 Tf 0.ise-i q 0

Selling D, Solimo A, Lee D, Horne K, Panove E, Venters H. Surveillance of suicidal and non-

Venters H, Gany, F. (2009) African Immigrant Health. 4/4/09. Journal of Immigrant and Minority Health

Venters H, Dasch-Goldberg D, Rasmussen A, Keller A, (2009) Human Rights Quarterly

Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, American Public Health Association Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees Venters H, Keller A, American Public Health Association Annual Meeting, Philadelphia, PA,

November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller AM, American Public Health Association Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award,

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, June 2015, June 2014, April 2019.

Instructor , Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture , Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo, Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/05-11/18.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

- Primary Project; Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French
- Secondary Project, Malaria Prevention.

Books

Venters H. Life and Death in Rikers Island. Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement in Jail. In Solitary Confinement Effects, Practices, and Pathways toward Reform. Oxford University Press, 2020.

MacDonald R. and Venters H. Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French	Proficient
Ewe	Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. NTX) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17.

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO. 16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Hutchinson v. Bates et. al. AL, No. 2:17-CV-00185-WKW- GMB, as expert for plaintiff 3/27/19.

Lewis v. East Baton Rouge Parish Prison, LA, No. 3:16-CV-352-JWD-RLB, as expert for plaintiff 6/24/19.

Belcher v. Lopinto, No. No. 2:2018cv07368 - Document 36 (E.D. La. 2019) as expert for plaintiffs 12/5/2019.

Fee Schedule

Case review, reports, testimony $500/hour.
Site visits and other travel, $2,500 per day (not including travel costs).

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Attorneys for Plaintiffs (continued from previous page)
*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

DECLARATION OF FRANCIS L. CONLIN

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

1. My name is Francis L. Conlin. I am the Chairperson for the Friends of Miami-Dade Detainees (FOMDD). FOMDD is a 501(c)(3) non-profit organization that advocates for immigrants. Our mission is to end isolation, curb abuse, spread awareness, and end immigrant detention. We accomplish our mission by operating visitation programs that offer friendship, a link to legal representation, phone time, books, and other support to immigrants in detention.

2. FOMDD operates visitation programs at Krome Service Processing Center (Krome) in Miami, Florida, Broward Transitional Center (BTC) in Pompano Beach, Florida, and Glades County Jail (Glades) in Moore Haven, Florida. FOMDD has operated visitation programs for over six years and has conducted over 3,000 visits to people in detention.

3. Since the outbreak of the COVID-19 pandemic, FOMDD volunteers have been in continuous contact with detained individuals at the three facilities we serve and have reported their findings to me.

4. All community visitation has been suspended at the three facilities since March 13, 2020. Only legal visits are allowed until further notice. We are not permitted to bring in cleaning supplies, masks, gloves, or hand sanitizer.

5. Based on FOMDD's knowledge and understanding, ICE and its contractors have not effectively disseminated vital information about COVID-19 to

13. FOMDD has documented ICE indiscriminately transferring people from Krome Service to other detention centers during this pandemic. Individuals are not being screened or getting their temperature checked before being transferred.

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Attorneys for Plaintiffs (continued on next page)

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

FAOUR ABDALLAH FRAIHAT, et al.,

Plaintiffs,

v.

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

Defendants.

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

Declaration of Laura G. Rivera in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

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

FAOUR ABDALLAH FRAIHAT, et al.,

Plaintiffs,

v.

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

Defendants.

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

Declaration of Jaimie Meyer in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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

I. BACKGROUND AND QUALIFICATIONS

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health,

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. To date, I am not being paid for my work in this case, although I am being paid $1,000 for my time spent on a case filed in federal court in New York involving similar issues. In making the following statements, I am not commenting on the particular issues posed by this case. Rather, I am making general statements about the realities of persons in jails and prisons.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. HEIGHTENED RISK OF EPIDEMICS IN JAILS AND PRISONS

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities:

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease,

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

and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

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

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

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

Defendants.

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

Declaration of Keren Zwick in Support of Motion for Preliminary Injunction and Class Certification

Date: March 24, 2020

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DECLARATION OF KEREN ZWICK

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

1. My name is Keren Zwick and I serve as the Director of Litigation at the National Immigrant Justice Center (NIJC). I have been an attorney at NIJC for nearly nine years, working as a litigator and direct service provider, focusing largely on asylum and protection-based claims for individuals in immigration detention.

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

3. NIJC operates numerous programs providing legal services to individuals in Immigration and Customs Enforcement (ICE) custody. Our Adult Detention Project provides direct legal representation and know-your-rights programming to immigrants in detention at the following facilities: the McHenry County Jail in Woodstock, Illinois; the Jerome Combs Detention Center in Kankakee, Illinois; the Boone County Jail in Burlington, Kentucky; the Clay County Detention Center in Brazil, Indiana; the Kenosha County Detention Center in Kenosha, Wisconsin; the Pulaski County Detention Center in Ullin, Illinois; and the Dodge County Detention Center in Juneau, Wisconsin.

4. In addition to the work of NIJC's Adult Detention Program other programs within NIJC serve detained individuals in other regions. For example, our LGBT Immigrant Rights Initiative provides direct representation services to immigrants who identify as LGBTQI throughout the country. Through this work, NIJC has routinely represented individuals in the Otay Mesa Detention Center in San Diego California, in the Cibola County Correctional Center in Milan, New Mexico, and in the South Texas Detention Complex in Pearsall, Texas. Several of NIJC's clients were transferred from Cibola to the Aurora Contract Detention Facility in Aurora, Colorado, when ICE unilaterally transferred the transgender detained population from Cibola.

5. Through a cooperative initiative with th

in detention. Numerous members of NIJC's staff have been involved in these interviews, and they have reported their findings to me.

8. Across the board, NIJC clients express a palpable fear about the vulnerability they face while remaining in detention during the COVID-19 pandemic. They are worried not only for themselves but for their families with whom they have difficulty communicating outside the detention centers. This fear is exacerbated by a universal perception that little to nothing has changed in the operation of the detention centers where they are housed since the onset of the pandemic. Our clients also universally report that neither ICE nor facility staff have provided them with meaningful information or education about the pandemic, leaving them to manage their anxieties and medical issues with little or no reliable information about what precautionary measures they could be taking.

Failure To Provide Information About COVID-19

9. Not one NIJC client in detention reports receiving reliable information or training about what COVID-19 is and precautionary measures that might be taken to halt its spread. Most clients reported that they received no information whatsoever from ICE or facility staff, much less medical staff, about the virus, and were learning what they knew almost exclusively from watching television.

10. Two clients detained at the Jerome Combs and another client detained at the Aurora Contract Facility reported that no one at the facility had communicated directly with them about the virus, but that they learned about the virus from the news.

11. Another client detained at McHenry reported that he knew about the virus because visitation was cancelled, and an official told him that if one person in detention got in contact with coronavirus, then everyone might be "down for a minute," but if the detainees got sick, they wouldn't let them go to the doctor. Others at McHenry confir.15 Td [(wh)3 (i)-2 (r)3 (.15 Td [(wh)3 (i)-2 (r)3 (.15 Td [(wh)3 (i)-2 (r)3 (.15 Td [5i)-2.)]ncH

32. We also sent a letter to the ICE Field Office Director for the Chicago Area of Responsibility inquiring about ICE's protocols and raising concern about the health and safety of our clients, but we have not received a response.

33. In the case of one of our clients facing prolonged detention in Aurora we amended a pending request for release to ask that COVID-19 be taken into consideration in the request for release for our client. We pointed out that ICE has the authority to release such individuals and cited notice from ICE stating that it would adjust detention practices as to new enforcement efforts. We got an immediate rejection notice to this request.

34. Additionally concerning, the ICE Field Office in Chicago indicated that it was closed, leaving us with little hope that requests pertaining to individual clients in our area will receive a response.

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

Executed on the 21st day of March, in the year 2020, in the city of Chicago, Illinois.

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UNITED STATES DISTRICT COURT
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FAOUR ABDALLAH FRAIHAT, et al.,

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

Defendants.

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

Declaration of Linda Corchado in Support of Motion for Preliminary Injunction and Class Certification

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DECLARATION OF MAUREEN A. SWEENEY, ESQ.

I, Maureen A. Sweeney, hereby declare:

1. I am a Law School Professor at the University of Maryland Carey School of Law, where I have taught Immigration Law, the Immigration Clinic, and other courses for sixteen years. I am also an attorney licensed to practice law in the state of Maryland. Prior to my work at the university, I practiced immigration law at Catholic Charities Immigration Legal Services and Lutheran Immigration and Refugee Services in Baltimore. My scholarly and practice areas of specialization are in immigration removal litigation, with particular specialty in the areas of asylum and the immigration consequences of criminal convictions. My curriculum vitae is attached as Exhiblumnc1immcho2n2MC LBody MCID 6 2BDC 1.5

mandatory detention. Our client did, in fact, fall within the terms of §1226(c), but after they detained him, ICE agents chose to exercise their discretion to

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DECLARATION OF MIKHAIL SOLOMONOV

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

1. I am over 18 years of age and am competent to make this Declaration. I make this Declaration based on personal knowledge. I read and write in English and Russian.
2. I am in the custody of Immigration a

temperature taken and filled out a questionnaire. We are up to 80 people in a dorm with capacity of 82 people, and it is impossible to stay away from other people in here.

7. We do not have access to hand sanitizer. No one in my dorm has been tested for COVID-19. The process for cleaning our dorm has not changed, and earlier this week we did not have enough rags to clean all of the surfaces in

and doing a screening questionnaire. I reiterated my earlier complaint that this is not enough to protect us.

12. It would be my strong preference to be home with my family sheltering in place and practicing social distancing.

13. Aurora's lack of preparedness is making me extremely worried for my safety and that of other detained people.

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

15. I have authorized attorney Elizabeth Jordan to sign this declaration on my behalf after she reviewed it with me over the telephone given the difficulty of arranging visitation and travel due to the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

Signature: [redacted]

Elizabeth Jordan for Mikhail Solomonov

Date: 3/21/2020

Location: Aurora, Colorado

5. In light of the above, to protect public health, I am not able to travel to Aurora Detention Center to obtain Mr. Solomonov's signature.
6. I spoke with Mr. Solomonov over the phone, interviewed him for a declaration, prepared the declaration, and then read the declaration to him and confirmed the accuracy of the information therein. Mr. Solomonov has confirmed that I can sign on his behalf

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*Admitted Pro Hac Vice
**Pro Hac Vice Application Forthcoming

DECLARATION OF THOMAS RAGLAND

1. My name is Thomas K. Ragland. I am a Member in the Immigration Business Unit of Clark Hill PLC. I work at the firm's Washington, D.C. office which is located at 1001 Pennsylvania Avenue NW, Suite 1300 South, Washington, DC 20004. I have practiced immigration law for over 25 years, including as an attorney at the Department of Justice's Board of Immigration Appeals and in the Office of Immigration Litigation at the Civil Division.

2. I represent a 63-year-old asylum seeker who is currently detained at the Adelanto Detention Facility ("Adelanto") in Adelanto, California. My client was taken into custody by U.S. Immigration and Customs Enforcement ("ICE") in June 2019. He is not subject to mandatory detention. In July 2019, an Immigration Judge ("IJ") at the Adelanto Immigration Court denied my client's motion for release on bond under INA §236(a), despite finding that he poses no danger to the community, on the ground that he poses a flight risk. On behalf of my client, I filed a timely appeal with the Board of Immigration Appeals ("BIA"). In February 2020, the BIA sustained our appeal and remanded my client's case to the Adelanto Immigration Court for a new bond hearing.

3. On March 12, 2020, the Adelanto Immigration Court issued a notice informing me that my client had been scheduled for a bond hearing on March 19, 2020.

4. On March 13, 2020, following discussions with the ICE counsel assigned to my client's case, we agreed upon stipulated terms for my client's release from custody: posting of a $30,000 bond and GPS electronic monitoring via an ankle bracelet.

5. On March 19, 2020, I appeared for a telephonic bond hearing before the IJ. ICE counsel was also present. The IJ informed me that he could not proceed with my client's bond hearing because he did not have the case file. He stated further that my client had been quarantined, for a reason unknown to him, and therefore was not present in the court. He stated that the bond hearing would thus have to be rescheduled. According to the IJ, to his knowledge the reason for the quarantine was not suspected coronavirus exposure, but he did not know why my client had been quarantined.

6. I informed the IJ that we had reached an agreement with opposing counsel on stipulated terms for my client's release. The IJ said he understood, but would not render a bond decision – notwithstanding the parties' stipulated agreement – without first reviewing the bond file, which he did not have before him. He stated further that my client could not be released for at least 2 weeks or 30 days in any event, due to quarantine policy at the Adelanto Detention Center.

7. The IJ stated that the earliest date on which he could conduct a bond hearing, when my client would be eligible for release from quarantine, is April 14, 2020 at 1:00 p.m.

8. Alarmed at the prospect that my client would languish for nearly another month in detention, I implored the IJ to release my client on the terms that ICE counsel and I had agreed to. I alerted the IJ to my client's advanced age and stated my concd m(l)-1.9 cd