IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

LEYANIS TAMAYO ESPINOZA
EDILIA DEL CARMEN MARTINEZ
JOSE RUBEN LIRA ARIAS
VIANKIS MARIA YANES PARDILLO
NDIKUM KESHIA ANGU ANJOH
ANTHONY BAPTISTE, and
LINDA CHUO FRU,

Petitioner-Plaintiffs,

v.

DIANNE WITTE, MATTHEW T. ALBENCE,
IMMIGRATION AND CUSTOMS
ENFORCEMENT, and
SHAWN GILLIS,

Respondent-Defendants.

DECLARATION IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER

Civil Action No.
5:20-cv106-DCB-MTP

DECLARATION OF CLIFF JOHNSON

I, Cliff Johnson, declare pursuant to 28 U.S.C. § 1746, as follows:

1. I am an attorney with the MacArthur Justice Center at the University of Mississippi School of Law. I represent Petitioner-Plaintiffs in this case.

2. For the convenience of the Court, I submit this declaration to attach copies of certain documents referred to in Plaintiffs' Memorandum of Law in Support of Motion for a Temporary Restraining Order.

3. The tables below list the exhibits attached to this declaration. Each exhibit is a true and correct copy of the document described in the second column.

Exhibit No.	Plaintiff Declarations
1	Declaration of Leyanis Tamayo Espinoza
2	Declaration of Edilia Del Carmen Martinez
3	Declaration of Jose Ruben Lira Arias
4	Declaration of Ndikum Keshia Angu Anjoh
5	Declaration of Viankis Maria Yanes Pardillo
6	Declaration of Anthony Baptiste
7	Declaration of Linda Chuo Fru

Exhibit No.	Expert Declarations
8	Declaration of Dr. Lydia Bazzano, MD, PhD, MPH, FACP
9	Declaration of Dr. Jaimie Meyer, MD, MS

Exhibit No.	Other Exhibits
10	Federal Orders & Opinions Releasing Individuals from Immigration Detention a. Hope v. Doll (M.D. Pa., Apr. 7, 2020) b. Fraihat v. Wolf (C.D. Ca. Mar. 30, 2020) c. Supreme Court of New Jersey Consent Order (Mar. 22, 2020) d. Calderon-Jimenez v.Wolf (D. Mass. Mar. 26, 2020)

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

Executed this sixteenth day of April, 2020 at Oxford, Mississippi.

/s/ Cliff Johnson

Cliff Johnson
cliff.johnson@macarthurjustice.org
MacArthur Justice Center
University of Mississippi School of Law
481 Chucky Mullins Drive
University, MS 38677

EXHIBIT 1

Declaration of Leyanis Tamayo Espinoza

I, Leyanis Tamayo Espinoza, declare as follows:

1. My name is Leyanis Tamayo Espinoza. I am a 46 year old Cuban woman currently detained at Adams County Correctional Center in Natchez, Mississippi.

2. I came to the United States to seek asylum because I was persecuted for my political opinion in Cuba. I have been detained since arriving in the United States seven months ago.

3. I was diagnosed with diabetes nine or ten months ago, while I was traveling to the United States. I also have been diagnosed with hypertension, and suffer from chronic kidney ailments which caused me to have a partial hysterectomy four or five years ago. I have had kidney stones three times, twice in Cuba and once now. They have not yet been removed or treated here.

4. For the diabetes I am given Metformin, and for the hypertension Amlodipine.

5. I suffer from many kidney issues and because they cannot treat me properly in this facility my symptoms are very severe. My kidneys can't retain water so my body is full of liquid everywhere. I have bags of water in my joints: from my knuckles to my knees and ankles. I also have bags under my eyes and cheeks.

6. About a month days ago I complained about my healthy kidney not feeling well. I was told that I have a bacteria by the medical staff at Adams, but they told me that they didn't have the requisite medicine to kill it. As a result, they only gave me ibuprofen and none of my symptoms are gone. I am incredibly swollen and in a lot of pain.

7. As a result of my many conditions I have very little appetite. Some days I get nauseous just from the thought of food and other days I cannot eat. Since I have been detained I have lost around 50 pounds. I have not been given any medication for this.

8. I also suffer from fever every 10-12 days, I can't be sure what temperature because we don't have thermometers but it must be around 100-102 degrees Fahrenheit. I had a fever a week ago and it let up 2 days ago. They took my temperature, and didn't tell me what the reading was. They just told me that I was fine and gave me Ibuprofen.

9. I am also constantly fatigued. I feel very tired all the time.

10. I don't know how many times I have visited the doctor while being here. I have probably seen a doctor once a month since detention started. However I have never seen the same person so there is no way to have consistency in my treatment. Also, the times I have seen a doctor are not the only ones I have sought treatment. When you ask to see a doctor you first see a nurse who comes to see you and ask you questions. Often, the nurse makes

a diagnosis and sends you medications. If you still want to see a doctor it takes about two weeks.

11. At my doctor visits I have gotten bloodwork and urinalysis, but I have never seen the results of these tests. Also I have never discussed with a doctor any of the results so I don't know what they say. All I know is that my symptoms remain and that I have not been given proper treatment for anything.

12. During one doctor visit this month, I was given a mammogram that I did not request and that I was not informed what was for. Also, I never received the results of that test.

13. I am very worried about my health and safety with the coronavirus going around because of my multiple health conditions. I am already losing a lot of weight, retaining a lot of liquid and getting inflamed, suffering from chronic fevers and not getting access to adequate care. Because of this, I fear that if the coronavirus gets in the jail, then I may die.

14. The sanitary conditions in the facility are not adequate. There are about 80 other women in my unit. Though I share one cell with another woman, we all eat together and use the same showers Although we clean daily, we are given only one very small bar of soap each week. These can run out easily. We also are responsible for cleaning the unit ourselves, but we don't have sufficient cleaning supplies and often cannot disinfect things in our dorm..

15. I am particularly worried about the food. The plates, utensils, soda machines, even water are dirty. It is very gross.

16. At the facility no one has said anything about coronavirus, we only learn from what is on TV. The guards say we are safe but we don't see them wearing gloves, masks or anything like that. On April, 13, 2020 an administrator at the detention center named Morris told us that there is no coronavirus here, but we know that that is not true.

17. We are very crowded in the facility. In the common areas there can be over 100 women gathering. There is no way for us to distance from each other, you always bump into people.

18. About 2 weeks ago, 15 days ago, 45 new women were transferred into our unit by ICE from Tallahatchie, Mississippi and from Texas.

19. Because I suffer from diabetes, hypertension, kidney failure, and malnutrition, I'm severely immunocompromised. I know this means that I am at extreme risk for serious injury or death from coronavirus. I don't think the medical facilities here are adequate to take care of me if I became infected. The only way to keep me safe is to release me.

20. If I were released, I would go live with my cousin on my mother's side in Miami, Florida. She is a US citizen and has lived in the United States for 18 years.

21. I have authorized an attorney to sign on my behalf, given the difficulty of arranging visitation and travel in light of the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

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

_____ Date: 4/15/2020

Jeremy Jong signing on behalf of Leyanis Tamayo Espinoza

EXHIBIT 2

Declaration of Edilia Del Carmen Martinez

I, Edilia Del Carmen Martinez, declare as follows:

1. My name is Edilia Del Carmen Martinez. I am a 53-year-old woman from El Salvador who is currently detained in Adams County Detention Center in Natchez, Mississippi. If I were released, I would go live with my friend Elizabeth Santoyo at 2631 East Childs Ave, La Merced, California 95341.

2. I have suffered from diabetes for 16 years which severely affects my immune system. It also causes dizziness and affects my kidneys. The dizziness has been frequent while I have been detained in this facility.

3. I have been given medication while being detained here, including recently. I am feeling very dizzy, and have had a headache and a cold for a few days. I also feel pain in my kidneys, and I went to the medical unit on Saturday. The doctor took a urine test and said I have an infection. She gave me a prescription for an antibiotic medication, but she also said my infection may be resistant to antibiotics.

4. I also suffer from chronic knee pain and stress which has become worse while being detained. I have to take insomnia medication as a result of the stress. I have begun to experience hair loss as well.

5. The conditions in the facility itself do not make me or anyone else feel safe because of the current coronavirus crisis. There is no space for social distancing. We all eat together in the dining area. ICE officers and guards have not told us anything about the virus. They don't talk to us. They only put up a poster telling us to wash our hands, and we learned most of what we know about the virus on the news.

6. The guards and staff do not consistently wear any protective gear or anything like that, even though they come in and out of the dorm each day. No one wears gloves. Recently a few staff started wearing masks.

7. There are about 120 people detained in my dorm, Charlie Charlie, at Adams. We all share 10 phones and 10 showers. We don't have gloves, and we were given one mask each for the first time on Monday.

8. I am very scared of the coronavirus because of my diabetes. I don't feel properly protected in this center. No one has really told us what is happening. We just know from the news. Because of my diabetes and my age, I feel like the best and safest thing would be to be released.

9. I have authorized an attorney to sign on my behalf, given the difficulty of arranging visitation and travel in light of the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

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

Date: April 16, 2020

Ghita Schwarz signing on behalf of Edilia Del Carmen Martinez

EXHIBIT 3

Declaration of Jose Ruben Lira Arias

I, Jose Ruben Lira Arias declare as follows:

1. My name is Jose Ruben Lira Arias, I am a 46-year-old Venezuelan man who is currently detained in Adams County Detention Center in Natchez, Mississippi.

2. I was detained the same day that I came into this country on December 25, 2019.

3. I suffer from diabetes which severely affects my immune system. My diabetes causes dizziness and I have developed leg pain. My blood sugar has been higher since being detained. They have not been able to control my blood pressure at the detention center.

4. I believe that the medical care here is inadequate. I have only seen the doctor twice since I've been here. It takes a very long time to see the doctor. When you put in your request, you usually should not expect to hear anything back immediately. By the time you see the doctor, the problem feels worse.

5. The conditions in the facility itself do not make me or anyone else feel safe because of the current coronavirus crisis. The ICE officers and guards don't wear gloves or masks. I asked the captain if he would tell his guards to put gloves and masks on because I felt very uncomfortable when they interacted with us. He told us that they weren't going to put masks and gloves on because they didn't have any.

6. The guards' only response to the coronavirus was to put up a poster about how long to wash our hands. They told us to wash our hands once and that's all we heard about the coronavirus. Most of what we know about the virus and ways to prevent it, such as social distancing, we learned through the news.

7. The facility is crowded and there is no space for social distancing. The dorms, or tanks as we call them here, are right next to each other, the common area and the phones are shared and are only cleaned once at night and once in the morning, not after every use as one would hope.

8. There has been no increase in cleaning since the coronavirus started and there is no bleach to clean the facilities.

9. Also, we do not have enough soap to really wash our hands or anything properly.

10. On April 9, 2020, 2 men from my tank were taken to the room where people have their court hearings over a video screen with other detained people from other tanks. One of the men from the other dorms in the courtroom had the coronavirus. After the court hearing, the two men from my tank returned and talked to us about what happened in court. Then, the staff came and took the two men out of our tank. I am not sure where they took them.

11. I have authorized an attorney to sign on my behalf, given the difficulty of arranging visitation and travel in light of the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

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

Date: 4/13/2020

Jeremy Jong signing on behalf of Jose Ruben Lira Arias

EXHIBIT 4

Declaration of Ndikum Keshia Angu Anjoh

I, Ndikum Keshia Angu Anjoh, declare as follows:

1. I am a 19-year-old Cameroonian woman currently detained by ICE at the Adams Correctional Center in Natchez, Mississippi. I was transferred here on or about March 3, 2020, from the T. Don Hutto Residential Center in San Antonio, Texas, where I was detained by ICE in December 2019.

2. I was transferred here with about 40 other Cameroonian women, who like me were seeking asylum. I do not know why we were transferred.

3. Since I was about nine years old, I have had difficulty breathing. It is worse at night when I am lying down. It feels like there is something on my chest blocking my breathing. I have to breathe in through my mouth. I never saw a doctor in Cameroon because it was expensive to see a doctor in my village.

4. Last year, I was arrested by the military in Cameroon. I was beaten and tied to a pillar, and pressed hard on the throat. I have a frequent cough from this injury, with a need to clear my throat all day. It makes my breathing even more difficult.

5. I have asked to see a doctor here but I have not yet seen one, and I have not been told when that will happen.

6. I was transferred here with about 39 other women from Hutto, and we were all together in a dormitory for a few days, joining women who were already here. I never saw a doctor in Hutto because medical staff always told their patients they were lying, and prescribed medication that was not related to the conditions people were suffering from. We complained to ICE officials.

7. A couple of weeks after being in Adams, they split our group into two different dormitories on or about 23 March 2020. My dormitory holds about 58 people.

8. There are four showers and twelve telephones for us, which are cleaned once a day. We eat in the dining area with people from other dormitories. It is very dirty, with tables that have food spilled on them. I rarely see anyone cleaning the dining room area. We stand and sit near each other when lining up for or eating food. Very rarely are we told to stand apart.

9. We don't have masks. The staff sometimes wears them, but I don't see them wearing gloves.

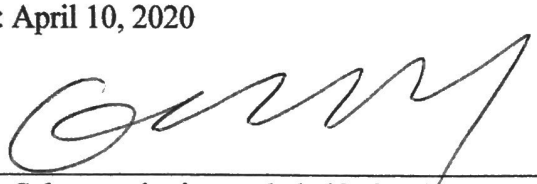
10. About two or three weeks ago, a group of women were transferred here. They were not allowed to come out of their dormitory, and ate inside their dormitory instead of going to the dining hall. It appeared that they were quarantined for about two weeks.

11. If I were released, I would go to live with my aunt in Arlington Texas, while my asylum claim is being heard. My hearing was supposed to be in May, but the court dates have been cancelled.

12. I have authorized my attorney to sign this declaration on my behalf, given the difficulty of arranging visitation and travel in light of the COVID-19 pandemic. If required, I will provide a signature when I am able to do so.

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

Date: April 10, 2020



Ghita Schwarz signing on behalf of Ndikum Keshia Angu Anjoh

EXHIBIT 5

Declaration of Viankis Maria Yanes Pardillo

I, Viankis Maria Yanes Pardillo, declare as follows:

1. My name is Viankis Maria Yanes Pardillo. I am a 49 year old Cuban woman currently detained at Adams County Correctional Center in Natchez, Mississippi.

2. I came to the United States to seek asylum because I was persecuted for my political opinion in Cuba.

3. I have been detained since arriving in the United States on August 31st, 2019.

4. I have had epilepsy since I got to the United States. I have had so many attacks that I lost track of how many. My first one was when I came in and I was detained at Karnes County Correctional Center in Texas. After my first attack I was hospitalized for three days.

5. That was the only time I was hospitalized. Since then after every attack I was only taken to the doctor in this facility.

6. I started getting medication but they did not get it right for a long time. I kept having attacks until about three months ago, when they put me on three different medications that I think have worked.

7. The attacks were awful. I felt like I was drowning and having a panic attack or something like that. After these attacks I lost consciousness and forgot where I was. I would eventually wake up, and people would tell me what had happened and remind me where I was.

8. As a result of my epilepsy I have a lot of issues with memory.

9. I am very worried about my health and safety with the coronavirus going around because of my health condition.

10. The sanitary conditions in the facility are only okay. We clean daily and they have been using more bleach since the virus started. However we still have very little soap and I worry about how clean things actually are.

11. At the facility, staff has said we are safer inside than outside because there are no infections inside and because there are doctors here, but I am not so sure that is true. I don't think it's very safe here.

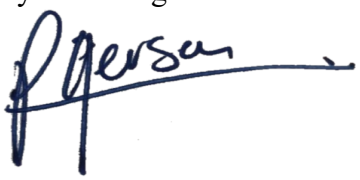
12. I don't know what social distancing is. No one has told me about that or anything like it.

13. I think the only way I will be safe given my condition is if I am released.

14. If I were released, I would go live with my daughter and her family who are Lawful Permanent Residents and live in Kentucky.

15. I have authorized an attorney to sign on my behalf, given the difficulty of arranging visitation and travel in light of the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

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



Date: March 27, 2020

Pedro Gerson signing on behalf of Viankis Maria Yanes Pardillo

EXHIBIT 6

Declaration of Anthony Baptiste

I, Anthony Baptiste, declare as follows:

1. My name is Anthony Baptiste. I am a 59-year-old man from Trinidad and Tobago who is currently detained at the Adams County Detention Center in Natchez, Mississippi. I have lived in the United States for over 40 years and I have been detained fighting my immigration case for almost three years now. If I were released, I would go live with my good friend Singh Deanarie at 316 Livingston Street, Brooklyn, New York, 11217.

2. I am mentally and physically disabled, and suffer from different medical conditions, including hypertension and pre-diabetes.

3. In 1998 I was run over by a car and both of my legs were broken. I still have back and leg pain from this injury and before I was detained I was getting Supplemental Security Income (SSI) based on this chronic disability. I still take medicine for pain at the jail.

4. On April 7, 2020 at around 12:15 in the afternoon I was going to see a counselor at the jail and there was some liquid on the floor. I slipped and fell and am now in the medical unit. I have a lot of back pain because of this. They say I need an x-ray but I haven't gotten one yet.

5. In April 2017, right before I was detained by ICE, I saw a doctor at Amsterdam Family Health. That doctor diagnosed me with borderline diabetes and essential hypertension. The doctor said I was a "high risk patient" and referred me to a cardiologist for a stress test and to a diabetes care management provider to give me counseling on lifestyle changes that could help me reduce my risk of developing diabetes. A few days after that appointment I was taken into ICE custody and was never able to follow up. I continue to suffer from prediabetes and hypertension while detained, and I take medicine for hypertension and for pain.

6. After my transfer to Adams last fall, I was referred to an outside clinic for testing due to an issue with my prostate. They told me things were "up and down" because of my age but that I was okay for now. I don't really understand what this means. I asked for my medical records which they gave me but I don't understand them.

7. As part of my immigration case, I was also diagnosed by a psychologist as being cognitively impaired. The psychologist found that my overall cognitive functioning is below the 10th percentile and that I demonstrated clear deficits in the areas of memory, language use, and abstract thinking. She also found that I exhibit variable concentration, attention, and delayed memory, and that I have difficulty paying attention, remembering questions that have just been asked, and committing information to shorter and longer term memory.

8. I am currently being housed in the medical unit. I am alone right now but people are always coming in and out to give me food or to check on me. Often these people are not wearing masks.

9. Before I was detained I was in cell 126 in the L unit. Although I was in a cell alone there is a common area, with phones which everyone uses and also computers which everyone uses.

10. They have not provided us with any masks and the guards who come in and out do not wear masks.

11. I am very scared of the coronavirus because of my hypertension and prediabetes, and also my age. It is my understanding that older people with these conditions are at greater risk of complications from the virus, including death. I do not have faith in the medical care I am getting here and I don't feel like I can protect myself. Because of my age and my heath conditions I am begging that you release me from detention.

12. I have authorized my immigration attorney to sign on my behalf given the difficulty of arranging visitation and travel in light of the current COVID-19 pandemic. If required to do so, I will provide a signature when I am able to do so.

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

Date: April 8, 2020

Katherine Buckel, signing on behalf of Anthony Baptiste

EXHIBIT 7

Declaration of Linda Chuo Fru

I, Linda Chuo Fru, declare as follows:

1. I am a 26-year-old Cameroonian woman currently detained by ICE at the Adams Correctional Center in Natchez, Mississippi. I was transferred here on or about March 3, 2020, from the T. Don Hutto Residential Center in Texas. I was detained there after I sought asylum at a port of entry in October, 2019.

2. While I was at T. Don Hutto, I experienced pain in my upper abdomen and went to the medical unit there. The doctor took some blood tests to see what was going on. He told me that I had Hepatitis B. He also said that once I leave the facility, I might need hospital care. I was not given medication or any treatment, only told that I should avoid taking Tylenol because it is dangerous for my liver.

3. Also at Hutto, I received a prescription for a bladder condition that I had had for several months. The medication helped. Sometimes, I also have high blood pressure, but I have not been given medication for that.

4. At the beginning of March, a group of about 120 women at Hutto were told to pack our bags and that we were being moved to a different facility. I arrived with 40 of those women at the Adams Correctional Center on March 3, 2020. When I arrived at Adams, they took blood for tests but I never received the results of those tests.

5. At Adams, I ran out of the medication I had been given. I went to the medical unit to talk about it, but they did not give me any treatment for it. I also asked about treatment for Hepatitis B, but the doctor at Adams told me there was no need for treatment. She did not take any blood tests. She said she had gone through my medical records, and that my liver and kidney are functioning, and I shouldn't be scared. But when I eat something it hurts. I have started to skip meals as a result.

6. I have headaches and trouble breathing at night, and have to use my mouth. I have had a cold for a few days and can't breathe through my nostrils. The medical unit has given me medicine for allergies to take every six hours, which also contains Tylenol, which I understood I was not supposed to take because of my liver condition. I don't feel that they are paying attention to my medical condition.

7. The name of my dormitory at Adams is Charlie Alpha, which houses 50 or 60 women. We are given soap and toothpaste for ourselves once a week. There are four showers for all of us, and they are cleaned by some of us about three times a week. No one supervises the cleaning.

8. I am paid $1.50 to clean the tables in the common areas and the microwave. I am not given masks for this, just gloves and a rag. I reuse the same rag every day after washing it in the sink and drying it on a slab.

9. A couple of weeks ago a group of new residents came in and were isolated, as if they were quarantined. A week or two later they were moved out.

10. We have heard about the coronavirus on CNN. There are signs here about keeping up hygiene because of COVID-19, but the staff have not discussed social distancing with us. The staff in the medical unit wear masks, but the staff in the rest of the facility do so only sometimes. I have not seen staff wearing gloves.

11. A few days ago I made my own mask out of white cloth and rope from a laundry bag. I wore it to the dining area, and a counselor who works here said to me, "Why do you have a mask on? We don't have a case of coronavirus, so you don't need it." So I took it off. But now they are telling us to sit one foot apart in the dining area, and yesterday they gave people in my dormitory one mask each.

12. I am scared for my health here. I have untreated Hepatitis B and other ailments that I am not getting adequate care for. I am fearful that if I contract the coronavirus, I will become seriously ill.

13. If I were released, I would go to live with my cousin Salvador Abumbi in Dallas, Texas, while my asylum claim is being heard.

14. I have authorized my attorney to sign this declaration on my behalf, given the difficulty of arranging visitation and travel in light of the COVID-19 pandemic. If required, I will provide a signature when I am able to do so.

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

Date: 04/14/2020

Ghita Schwarz signing on behalf of Linda Chuo Fru

EXHIBIT 8

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

Leyanis Tamayo Espinoza et al., *Petitioners-Plaintiffs*, v. Dianne Witte et al., *Respondents-Defendants*.	Civil Action No.:

DECLARATION OF Lydia Angela Louise Bazzano, MD, PhD, MPH, FACP

I, Lydia Bazzano, 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.

I. Background

1. I am Dr. Lydia Angela Louise Bazzano. I am a senior physician and Executive Chair of the Ochsner Institutional Review Board at Ochsner Health System (OHS), and Professor of Epidemiology at the Tulane University School of Public Health and Tropical Medicine, where I direct the Center for Lifespan Epidemiology Research. A fellow of the American College of Physicians and Diplomate of the American Board of Internal Medicine, I did my residency training at the Beth Israel Deaconess Medical Center Internal Medicine Residency program in Boston, Massachusetts associated with the Harvard Medical School. I received my medical degree from Tulane University School of Medicine and a Master of Public Health Degree (MPH) as well as a Doctor of Philosophy (PhD) in Epidemiology from the Tulane University School of Public Health and Tropical Medicine.

2. As a professor of Epidemiology at Tulane University School of Public Health and Tropical Medicine, I teach classes in Clinical Epidemiology, which is a subfield of epidemiology focused on the issues relevant to clinical medicine. Epidemiology is commonly defined as the investigation and control of the distribution and determinants of disease in populations. Clinical epidemiology involves the application of population level principles of epidemiology to the individual care of patient in clinical medicine. In this capacity, I teach medical students in the dual degree MD/MPH and MD/PhD programs in Epidemiology, as well as students of public health in the MPH program.

3. As a Senior Physician in the Department of Internal Medicine at Ochsner Health System, I supervise residents in the Internal Medicine in the ambulatory primary care clinic. Prior to this position, from 2012 to 2014, I served as a physician in the Department of Hospital Medicine, attending patients admitted to medical units at the main campus of Ochsner Hospital, located at 1514 Jefferson Highway in New Orleans, Louisiana. In addition, I currently serve as the Executive Chair of the Ochsner Institutional Review Board, which protects the rights of human participants in clinical research.

4. I have broad expertise in the fields of Epidemiology and Internal Medicine with more than 170 peer-reviewed publications in across a range of health outcomes including but not limited to infectious, cardiovascular and metabolic diseases.

5. My CV is attached as Exhibit A.

II. COVID-19 in Rural Mississippi and Louisiana

6. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. COVID-19 has now reached pandemic status. At the time of this

declaration, 3360 people have been diagnosed with COVID-19 in Mississippi, 37,733 people have been tested for SARS-CoV-2, 645 have been hospitalized, and 122 have died.[1] In Louisiana, 21,951 people have been diagnosed with COVID-19 in Louisiana, 121,928 people have been tested for SARS-CoV-2, 1,943 of those people are hospitalized with 425 requiring mechanical ventilation, and 1103 deaths have been reported.[2] The numbers of infection and death in the United States as a whole, and in Mississippi specifically, are likely underestimated due to the lack of test kits available.

7. The growth rate of COVID-19 cases in Mississippi and Louisiana has been rapid and is expected to outpace hospital bed capacity and Intensive Care Unit (ICU) capacity across the state in both urban and rural counties and parishes.[3] Even the most conservative epidemiologic models of virus transmission in which only 20% of the population become infected with SARS CoV-2 indicate that the need for hospital beds, ICU beds, and ventilators for mechanical ventilation will far exceed the currently available supply, and even an augmented supply.[4]

8. The population of Mississippi has a high prevalence of co-occurring underlying medical conditions that increase vulnerability to severe disease from the virus. The CDC identified underlying medical conditions that may increase the risk of serious COVID-19 for

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[1] Data available at https://msdh.ms.gov/msdhsite/_static/14,0,420.html#tests, Mississippi State Department of Health, accessed April 15, 2020.

[2] Louisiana Department of Public Health Coronavirus (COVID-19) interactive map, available at http://ldh.la.gov/Coronavirus/, accessed April 15, 2020.

[3] Erica Hensley, *Amid first reported death, Mississippi hospitals brace for COVID-19 'tidal wave,'* Mississippi Today (Mar. 19, 2020), *available at* https://mississippitoday.org/2020/03/19/amid-first-reported-death-mississippi-hospitals-brace-for-covid-19-tidal-wave/; Carter Simoneaux, *Flattening the Curve: Taking a Look at Louisiana's Hospital Capacity*, *available at* https://kadn.com/flattening-the-curve-taking-a-look-at-louisianas-hospital-capacity/; Peter Sullivan, *Louisiana governor warns New Orleans could run out of ventilators by early April,* The Hill, *available at* https://thehill.com/policy/healthcare/489532-louisiana-governor-warns-new-orleans-could-run-out-of-ventilators-by-early.

[4] *How will hospitals accommodate a growing number of COVID-19 patients?* Harvard Global Health Institute COVID-19 Hospital Capacity Estimates 2020 https://globalepidemics.org/.

individuals of any age, including high blood pressure, metabolic disorders (such as diabetes), heart and lung disease, and neurologic conditions. States in the Mississippi Delta region, including Mississippi and Louisiana, lead the nation in prevalence of chronic diseases such as hypertension with age standardized prevalence of 37.5% and 40.1% of the population of each state, respectively, self-reporting hypertension compared to 28.9% nationally.[5] For asthma, Mississippi ranks 50th in the nation with prevalence of 12.1% of the population having asthma compared to a national prevalence of 7.9%, and for diabetes, Mississippi ranks 48th in the nation with prevalence of 14.3% of the population having diabetes compared to a national prevalence of 10.9%. 5.3% of Mississippi's population suffers from cardiovascular (heart) disease compared to 4.2% nationally, and 4.8% of Mississippi's population has suffered stroke (neurologic disease) compared to only 3.4% nationally.[6] The percentage of Medicare enrollees with four or more chronic conditions (multiple chronic conditions) in Mississippi is nearly 40 % compared to 37.8% nationally. Because of this high prevalence of co-morbid conditions in the population of Mississippi (as well as other states in the Southern Mississippi Delta), vulnerability to severe disease from SARS CoV-2, requiring hospitalization and ICU level of care, as well as mechanical ventilation, is likely to be greater than in other regions or states, diabetes, and cardiovascular diseases, further taxing the limited medical infrastructure.

9. For the aforementioned reasons, the hospitalization rate and requirements for ICU level care due to severe COVID-19 are likely to be higher in Mississippi than in other states where co-occurring underlying conditions are less frequently manifested in the general population.

[5] Fang J, Gillespie C, Ayala C, Loustalot F. Prevalence of Self-Reported Hypertension and Antihypertensive Medication Use Among Adults Aged ≥18 Years — United States, 2011–2015. MMWR Morb Mortal Wkly Rep 2018;67:219–224 https://www.cdc.gov/mmwr/volumes/67/wr/mm6707a4.htm?s_cid=mm6707a4_w

[6] Data available at https://www.americashealthrankings.org/health-topics, accessed April 15th, 2020.

III. COVID-19 in Rural Mississippi

10. Rural medical infrastructure and capacity has been decreasing over time.[7] Individuals in rural counties of Mississippi and neighboring Southern states face more barriers to fast and efficient medical care than those in urban areas due to declining medical infrastructure. Most rural hospitals have very limited ICU capacity and few ventilators as compared to hospitals and medical facilities in urban areas. Based on regional estimates of hospital capacity in Mississippi,, demand for ICU and hospital beds will far outpace availability. Mississippi has an estimated 931 total ICU beds, with an estimated 392 available. However even using the best case scenario estimate of transmission (20% infected) approximately 20,261 individuals would need ICU level care due to infection, which would require approximately 1351 ICU beds needed in the next 6 months alone.[8] More realistic models of transmission with a 40% or 60% rate of infection project a severely insufficient hospital and ICU bed capacity in rural areas which has a very strong potential to result in a large number of excess deaths.

11. Severe COVID-19 cases that exceed rural medical capacity will require transfer to urban hospitals where ICU and mechanical ventilation capacity is expected to be higher. However, demand for hospital and ICU beds in urban areas is expected to far exceed supply as well, resulting in delays in transfer of care until beds become available, if at all.

12. Geographic transfer of patients who are infected and exhibiting severe signs of COVID-19, if possible, from rural to urban medical centers may require several days and could be associated with poorer outcomes due to the transfer itself. In addition, transfer of patients

[7] A Sense of Alarm as Rural Hospitals Keep Closing. New York Times. October 29, 2018. https://www.nytimes.com/2018/10/29/upshot/a-sense-of-alarm-as-rural-hospitals-keep-closing.html

[8] Data available at https://globalepidemics.org/2020/03/17/2020-03-17-caring-for-covid-19-patients/ Harvard Global Health Institute, COVID-19 Hospital Capacity Estimates, accessed April 11, 2020.

with an infectious respiratory organism that can remain airborne for significant lengths of time poses risks for transmission to medical staff and others.

IV. COVID-19 in ICE Detention Centers in Rural Mississippi and Louisiana

13. Community transmission is occurring across the states of Mississippi and Louisiana. As of April 15, 2020, every Mississippi county has reported cases of COVID-19, including Adams County, where ICE's detention center at Adams Correctional Center is located. Mississippi reports 3360 cases of COVID-19 across the state, with 64 in Adams County and 51 in neighboring Wilkinson County.[9] The Adams County Correctional Center, where plaintiffs are detained, now has 5 confirmed cases of COVID-19.[10] Staff at detention facilities are likely to become infected and transmit the infection to other staff and detainees. Due to the lack of systematic nationwide testing, it is likely that infections will occur and go undetected during several days of incubation, which are typically asymptomatic.

14. After SARS CoV-2 infection has occurred in a facility, it is highly unlikely to be contained using the procedures outlined in the Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19). Many aspects of congregative environments such as ICE detainment facilities make it difficult if not impossible to contain transmission. In Louisiana, 1320 COVID-19 cases have been reported in 124 nursing homes, with 275 deaths.[11] In Mississippi, there

[9] Data available at https://msdh.ms.gov/msdhsite/_static/14,0,420.html#caseTable, Mississippi State Department of Health, Mississippi COVID-19 Case Map, accessed April 15, 2020.
[10] ICE Guidance on COVID-19, Confirmed Cases, available at https://www.ice.gov/coronavirus, accessed April 15, 2020.
[11] Data available at Louisiana Department of Health Updates for 4/15/2020, available at http://ldh.la.gov/index.cfm/newsroom/detail/5548, accessed April 15, 2020.

have been 66 outbreaks of COVID-19 in long-term care facilities, including 2 in Adams County.[12]

15. The protocol for detection and containment of COVID-19 in ICE facilities relies in part on questioning detainees about travel and sick contacts. These questions are likely to be unreliable and provide a false sense of security given the broad community-based transmission occurring in Mississippi and Louisiana. Staff themselves are likely exposed and bring the virus into the congregative environment during the asymptomatic period prior to fever and respiratory symptoms. Efforts to isolate detainees who have become infected are not likely to effectively contain infection because of the characteristics of the SARS CoV-2 virus and its long duration of airborne transmission due to small aerosolized particles. Only specialized negative pressure isolation rooms are documented to be effective against transmission due to small aerosolized particles.

V. Specific Cases

16. The 7 plaintiffs in this lawsuit present with personal health characteristics that put them at high to very high risk for complications from COVID-19 should they be exposed to the virus in detention.

a. Ms. Leyanis Tamayo Espinoza (46, F) suffers from Diabetes, hypertension, chronic renal issues. This person is at a very high risk for complications related to the novel coronavirus due to her co-occurring multiple chronic conditions (multi-morbidity). Kidney disease renders one more susceptible to infections. Chronic

[12] Data available at https://msdh.ms.gov/msdhsite/_static/14,0,420.html#map, Mississippi State Department of Health, Mississippi COVID-19 Case Map, accessed April 15, 2020.

renal (kidney) issues also limit the use of many medications to treat symptoms because most medications are cleared through the kidneys.

b. Ms. Edilia Del Carmen Martinez (53, F) suffers from Diabetes and kidney issues. She is at a very high risk for complications related to the novel coronavirus due to her co-occurring multiple chronic conditions (multi-morbidity). Chronic renal (kidney) issues also limit the use of many medications to treat symptoms because most medications are cleared through the kidneys. Kidney disease renders one more susceptible to infections, and may also limit the use of many medications to treat symptoms because most medications are cleared through the kidneys.

c. Mr. Jose Ruben Lira Arias (46, M) Suffers from Diabetes and high blood pressure. This person is at a higher risk for complications due to his diagnosis of diabetes.

d. Ms. Viankis Maria Yanes Pardillo (49, F) suffers from a seizure disorder. Her age in addition with concomitant neurologic disorder puts her at a high risk for complications from COVID-19. Some medications used to treat seizures may affect a person's immune system. In addition, bodily fluids such as saliva which are difficult to control during a seizure event could pose a hazard to staff or other detainees.

e. Ms. Ndikum Keshia Angu Anjoh (19, M) suffers from a respiratory disorder and has throat injury. This person is at a high risk for complications related to the novel coronavirus due to her difficulty breathing, for which she has received only allergy medication.

f. Mr. Anthony Baptiste (59, M), suffers from hypertension, for which he receives medication, and pre-diabetes, for which he does not. He was disabled in a car accident and has cognitive impairments. He is at very high risk for complications related to the novel coronavirus due to his age combined with his hypertension and untreated pre-diabetes.

g. Ms. Linda Chuo Fru (26, F), has been diagnosed while in detention with Hepatitis B, for which she has not received any treatment. She also has high blood pressure and a bladder condition. She is at very high risk for complications related to the novel coronavirus due to her untreated liver disease.

VI. Conclusion and Recommendations

17. For the reasons above, it is my professional judgment that the plaintiffs, currently at the Adams Correctional Center in Mississippi, are at high risk of contracting SARS CoV-2 due to living in a congregative environment, and that they are much more likely to experience poor outcomes including multiorgan failure and death if they do become infected because of the shortage of rural hospital infrastructure and capacity.

18. Given transmission rates based on even the most conservative epidemiologic models, bed capacity in urban areas is likely to be far exceeded thus transfer to those hospitals will be improbable or impossible and poses risks to both the patient, health care workers, and others.

19. The recommendations of the ICE Health Service Corps embodied in Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19) will not be sufficient to prevent

infection in ICE detention facilities in Mississippi and Louisiana where community transmission is occurring in all counties and parishes.

VII. Expert Disclosures

None.

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

Signature: Date: April 15, 2020

Location: Metairie, LA

Lydia Bazzano

Exhibit A

Lydia Bazzano January 7, 2020

CURRICULUM VITAE

Lydia Angela Louise Bazzano, MD, PhD, MPH
Tulane University School of Public Health and Tropical Medicine
Full Professor of Epidemiology
Ochsner Clinic Foundation
Senior Physician, Internal Medicine

CONTACT INFORMATION

Business Address: Tulane University Health Sciences Center
School of Public Health and Tropical Medicine
Department of Epidemiology
1440 Canal St., Suite 2034
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1401-A Jefferson Hwy, 2nd Floor
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Business Telephone and fax: (504) 988-7323 –T office; (504) 842-3535 - O office
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Business email Address: lbazzano@tulane.edu
lbazzano@ochsner.org

Home Address: 4401 Avron Blvd.
Metairie, LA 70006

Citizenship: USA

Gender: Female

Marital Status: Married

Number of Children: Number of Children: 1

EDUCATION

Bachelor of Science Summa cum Laude (Ecology and Environmental Biology), May 1996
Newcomb College, Tulane University, New Orleans, Louisiana

Doctor of Philosophy (Epidemiology), December 2000
Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana

Doctor of Medicine, May 2002
Tulane University School of Medicine, New Orleans, Louisiana

Master of Public Health (Epidemiology), May 2002
Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana

POST-DOCTORAL TRAINING

June, 2002- July, 2003	Internship in Internal Medicine Department of Medicine Beth Israel Deaconess Hospital Harvard School of Medicine Boston, Massachusetts
June, 2003-July, 2005	Residency in Internal Medicine Department of Medicine Beth Israel Deaconess Hospital Harvard School of Medicine Boston, Massachusetts

LICENSURE AND CERTIFICATIONS

1996-present	Basic Life Support Certification (BLS)
2002-present	Advanced Cardiac Life Support Certification (ACLS)
2003-present	United States Medical Licensure Examination Certification
2002-2009	Massachusetts Medical Licensure
2005-present	Louisiana Medical Licensure
2005-present	Diplomate, American Board of Internal Medicine Certification
2015-present	Certified Institutional Review Board Professional (CIP)
2017-present	Diplomate, American Board of Obesity Medicine Certification

ACADEMIC APPOINTMENTS

July, 2019-	Professor of Epidemiology, Tulane University School of Public Health and Tropical Medicine
July, 2014-	Lynda B & H Leighton Steward Professorship in Nutrition Research Director, Center for Lifespan Epidemiology Research Department of Epidemiology, Tulane University School of Public Health and Tropical Medicine
January, 2013-	Senior Lecturer, University of Queensland School of Medicine Ochsner Clinical School
July, 2012	Associate Professor of Epidemiology (with Tenure), Tulane University School of Public Health and Tropical Medicine
July, 2005-2012	Assistant Professor of Epidemiology, Tulane University School of Public Health and Tropical Medicine
July, 2005-2013	Clinical Assistant Professor of Medicine, Tulane University School of Medicine
June, 2007	Adjunct Assistant Professor, Pennington Biomedical Research Center, Louisiana State University

CLINICAL PRIVLEDGES AND APPOINTMENTS

2019-	Senior Staff Physician, Internal Medicine, Ochsner Medical Center, Jefferson, LA
2012 -2019	Active Staff Physician, Internal Medicine, Ochsner Medical Center, Jefferson, LA
2005-2012	Active Staff Physician, Internal Medicine, Tulane Lakeside Hospital, Metairie, LA
2005-2012	Active Staff Physician, Internal Medicine, Tulane HCA Hospital, New Orleans, LA
2006-2012	Active Staff Physician, Internal Medicine, Medical Center of Louisiana at New Orleans, New Orleans, LA

HONORS AND AWARDS

1996	Phi Beta Kappa National Honor Society Newcomb College, Tulane University
1996	Fred R. Cagel Memorial Award in Biology Newcomb College, Tulane University
2000	Population Research Award in Epidemiology Tulane University School of Public health and Tropical Medicine

2002 Jeremiah and Rose Stamler Research Award, Finalist
American Heart Association, Council on Epidemiology and Prevention

2002 Janet M. Glasgow Memorial Achievement Citation
American Medical Women's Association
Tulane University School of Medicine

2002 Medical Student Award
American Federation for Medical Research
Tulane University School of Medicine

2002 Alpha Omega Alpha Medical Honor Society
Tulane University School of Medicine

PUBLIC POLICY ACTIVITY

2020-2025 Dietary Guidelines for Americans Advisory Committee *I have been appointed to the 2020 Committee, https://www.cnpp.usda.gov/dietary-guidelines*

2005-2015 Dietary Guidelines for Americans *My work has been cited in the Scientific Report from the Dietary Guidelines Advisory Committee in each year (2005, 2010, 2015) of guidelines over the past 15 years*

- Scientific Report of the 2015 Dietary Guidelines Advisory Committee: Advisory Report to the Secretary of Health and Human Services and the Secretary of Agriculture. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC, Appendix E-2: Supplementary Documentation to the 2015 DGAC Report - Dietary Guidelines Advisory Committee. 2015. Appendix E-2.26, 27, 28: Evidence Portfolio

- Dietary Guidelines Advisory Committee. 2010. Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2010, to the Secretary of Agriculture and the Secretary of Health and Human Services. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC.

- Dietary Guidelines Advisory Committee. 2005. Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2005, to the Secretary of Agriculture and the Secretary of Health and Human Services. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC. Part D. Science Base Section 6: Selected Food Groups (Fruits and Vegetables, Whole Grains, and Milk Products)

United States Preventive Services Task Force *My work has been referenced in the following.*

- Selph S, Dana T, Blazina I, Bougatsos C, Patel H, Chou R. Screening for type 2 diabetes mellitus: a systematic review for the US Preventive Services Task Force. Annals of Internal Medicine. 2015 Jun 2;162(11):765-76.

American Heart Association/American College of Cardiology, Guidelines and Statements *My work has been referenced in all of the following guidelines and statements*

- Eckel RH, Jakicic JM, Ard JD, De Jesus JM, Miller NH, Hubbard VS, Lee IM, Lichtenstein AH, Loria CM, Millen BE, Nonas CA. 2013 AHA/ACC guideline on lifestyle management to reduce cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2014 Jul 1;63(25 Part B):2960-84.

- Smith SC, Benjamin EJ, Bonow RO, Braun LT, Creager MA, Franklin BA, Gibbons RJ, Grundy SM, Hiratzka LF, Jones DW, Lloyd-Jones DM. AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation endorsed by the World Heart Federation and the Preventive Cardiovascular Nurses Association. Journal of the American College of Cardiology. 2011 Nov 29;58(23):2432-46.

- Goldstein LB, Adams R, Alberts MJ, Appel LJ, Brass LM, Bushnell CD, Culebras A, DeGraba TJ, Gorelick PB, Guyton JR, Hart RG. Primary prevention of ischemic stroke: A guideline from the American heart association/American stroke association stroke council: Cosponsored by the atherosclerotic peripheral vascular disease interdisciplinary working group; cardiovascular nursing council; clinical cardiology council; nutrition, physical activity, and metabolism council; and the quality of care and outcomes research interdisciplinary working group: The American academy of neurology affirms the value of this guideline. Stroke. 2006 Jun 1;37(6):1583-633.

- Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, Konstam MA, Mancini DM, Michl K, Oates JA. ACC/AHA 2005 guideline update for the diagnosis and management of chronic heart failure in the adult—summary article: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure). Journal of the American College of Cardiology. 2005 Sep 20;46(6):1116-43.

- Mosca L, Appel LJ, Benjamin EJ, Berra K, Chandra-Strobos N, Fabunmi RP, Grady D, Haan CK, Hayes SN, Judelson DR, Keenan NL. Evidence-based guidelines for cardiovascular disease prevention in women. Journal of the American College of Cardiology. 2004 Mar 3;43(5):900-21.

World Health Organization *I was invited to give a presentation at a joint conference of the World Health Organization and the food and Agriculture Organization on "Effects of Fruits and Vegetables on Risk of CVD and Diabetes".*

- World Health Organization. Fruit and vegetables for health: report of a Joint FAO/WHO Workshop, 1-3 September, 2004, Kobe, Japan. Available at: http://www.fao.org/3/a-y5861e.pdf Accessed 10/28/2018

PROFESSIONAL MEMBERSHIPS AND OFFICES

1997-	Member of the American Medical Association
2003-2009	Member of the Massachusetts Medical Society
2005-	Member of the Louisiana State Medical Society
2005-	Member of the Society of General Internal Medicine
2005-	Member of the Nutrition and Epidemiology Councils, American Heart Association
2007	Fellow, American College of Nutrition
2008-2011	Elected Member, Evidence Based Medicine Task Force, Society of General Internal Medicine
2012	Member, Southern Society for Clinical Investigation
2013	Fellow, American College of Physicians
2016-	Member, American Association of University Professors
2017-2018	Board Member, American Association of University Professors, Tulane Chapter
2017-present	Elected Councilor, Executive Council, Southern Society for Clinical Investigation

NATIONAL AND INTERNATIONAL COMMITTEES

Study Section and Scientific Reviews

NIHR-CCF (National Institute for Health Research Central Commissioning Facility for UK Department of Health) Peer review for Department of Health Applied Research Program– "Delivering the Diabetes Prevention Program in a UK Community Setting," 2006

Member, National Board of Public Health Examiners 2008 Item-Writing Committee, Meetings September 28-29th, 2006 and September 10-11th,2007

Office of Dietary Supplements, National Institutes of Health, Reviewer for 2007 Annual Bibliography of Significant Advances in Dietary Supplements Research, 2007

Ad-hoc Member, Health Services Organization and Delivery (HSOD) Study Section, National Institute of Health, Center for Scientific Review, February 5-6th, 2009

Member, External Advisory Panel, Peer review for Dry Grain Pulses Collaborative Research Support Program (CRSP), Office of Agriculture, EGAT, United States Agency for International Development (USAID), October 16th, 2009

Member, Special Emphasis Panel, National Institutes of Health, Center for Scientific Review, Internet Assisted Review, February 16-18th, 2011

Member, Special Emphasis Panel reviewing applications for the RFA HL-12-004 entitled "Maximizing the scientific value of the NHLBI biologic specimen repository: Scientific opportunities (R21)", National Institutes of Health, Center for Scientific Review, November 7, 2012

Ad-hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review**,** June 13th-14th, 2013

Ad-hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, October 15th-16th, 2015

Member, Contract Review Panel, National Institute of Child Health and Human Development, Center for Scientific Review, ZHD1 DSR-K (DD), August 23rd, 2016.

Ad hoc Member, Cancer, Heart, and Sleep Epidemiology Study Section - A (CHSA), National Institute of Health, Center for Scientific Review, October 27th-29th, 2016

Ad hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, February 5th-6th, 2018

Regular Appointed Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, July 1, 2018 - 2022

SERVICE

Journal Reviewer

American Journal of Clinical Nutrition
British Journal of Nutrition
Nutrition, Metabolism & Cardiovascular Disease
American Journal of Epidemiology
Annals of Neurology
Annals of Internal Medicine
Canadian Medical Association Journal
Circulation
Diabetes Care

Epidemiology
Hypertension
JAMA (Journal of the American Medical Association)
JAMA Internal Medicine
Journal of the American College of Nutrition
Kidney International
Lancet
Nature
Public Library of Science (PLoS) One
Public Library of Science (PLoS) Medicine
Stroke
Science

Journal Editorial Boards

2011-present Nutrition Metabolism and Cardiovascular Disease

Academic Committees

2005-present Member, Tulane MD/MPH Advisory Committee

2008-2010 Chair, Tulane MD/MPH Advisory Committee

2006-2008 Member, Tulane SPH&TM Culminating Exam Committee

2008, 2017 Chair, Tulane Epidemiology Faculty Search Committee (Cardiovascular Epidemiology)

2009-2012 Member, Program Committee, Tulane Interdisciplinary PhD in Aging Studies

2009-2014 Alternate Member, Tulane University Biomedical Institutional Review Board

2017-2018 Secretary, General Faculty, Tulane School of Public Health & Tropical Medicine

2018-2021 Senator, Tulane University Senate (3 year term)

2012-present Steering Committee Member, Building Interdisciplinary Research Careers in Women's Health (BIRCWH)

2014-present Ochsner Institutional Review Board, Chair Panel A

2014-present Chair, Bogalusa Heart Study Steering Committee, Tulane University

2019-present Advancement, Promotion and Tenure Committee, Tulane School of Public Health & Tropical Medicine

Other Committees

2011-2012 Alternate Member, New Orleans VA Institutional Review Board

CONSULTANCIES

2017-2020 Mizkan Ltd – consultancy to provide scientific and clinical input in the design and operation of a clincal trial examining the effects of a vinegar beverage on blood pressure in black and white men and women with pre-hypertension as defined in the most recent national guidelines.

2015-2016 Wellness and Nutrition Advisory Board (WNAB) – consultancy organized by Sabra Dipping Company to advise the company regarding scientific advances in nutrition which provide a strategic opportunity to promote healthy dietary patterns incorporating hummus and other Sabra products.

2007-2009 Bean Expert Advisory Panel (BEAN) – consultancy organized by Bush Beans. The Panel is composed of 11 nationally renowned food and nutrition, health, and culinary experts who advise on ways to help Americans achieve the 2005 Dietary Guidelines recommendation to consume 3 cups per week of legumes, such as beans, as part of a healthy diet

TEACHING

Current

Course Director	EPID 6420 Clinical Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2007-present)
Course Director	EPID 6430 Clinical and Translational Research Methods (Tulane University School of Public Health and Tropical Medicine, 2018-present)
Lecturer	EPID 790 Advanced Epidemiology Methods (Tulane University School of Public Health and Tropical Medicine, 2008-2011)
Lecturer	EPID 6220 Cardiovascular Disease Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2000-2002, 2005-present)
Lecturer	EPID 6500 Nutritional Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2017-present)

Lecturer	SPHU 3200 Nutrition and Chronic Disease (Tulane University School of Public Health and Tropical Medicine, 2015-present)

Past

Course Director	EPID 6220 Cardiovascular Disease Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2009-2012)
Lecturer	EPID 6430 Clinical and Translational Research Methods (Tulane University School of Public Health and Tropical Medicine, 2015-2017)

Students Advised Each Year by Level of Degree

Master Students (by year of graduation or expected)

2007	Kristina Lewis (MD/MPH) Jeffrey Wolters (MD/MPH) Hannan Natalia (MD/MPH) Ulana Pogribna (MD/MPH)
2008	Melissa DeVito (MD/MPH) Kyle Fargen (MD/MPH) Mary McDonald (MD/MPH) Jeannie Rhee (MD/MPH) Ajay Tejwanti (MD/MPH) Michael Tees (MD/MPH)
2009	Eduardo Castro-Echeverry (MD/MPH) Joseph Prows (MD/MPH) James Lukens (MPH) Margaret Jones (MD/MPH) Katherine Kerisit (MD/MPH) Jason Collins (MPH) Bridgette Collins-Burrow (MPH) Nedret Copur (MPH) Houman Dahi (MPH) Christiane Hadi (MPH) Julie Kumata (MPH) T C Narumanchi (MPH) Supat Thammasitboon (MPH) Aggarwal, Shivang (MPH)
2010	Jordan Awerbach (MD/MPH) Kelly Lafaro (MD/MPH) Oni Olirunde (MS) Eric Richter (MS-CR)

	Sindjuja Marupudi (MPH)
	Alina D. Fotino (MPH)
2011	Aaron Boojindasum (MD/MPH)
	Jordan Hoffman (MD/MPH)
	Edward Mannina (MD/MPH)
	Ashley Nitschke (MD/MPH)
	Snow Petersen (MD/MPH)
	Tina Wang (MD)
	Brian Zwecker (MD/MPH)
	Jerome Crowley (MD/MPH)
	Supat Thommasitboon (MPH)
2012	David Bateman (MD/MPH)
	Daniel Bourgeois III (MD/MPH)
	Joanne So (MD/MPH)
	Thomas Jan (MD/MPH)
	Kutaiba Al-Shebeeb (MPH)
	Palwasha Anwari (MPH)
	Cassandra J. Heiselman (MPH)
2013	Kayleen Bailey (MD/MPH)
	David German (MD/MPH)
	Michael R. Halstead (MD/MPH)
	Marsha Smith (MD/MPH)
2014	Mohamed H. Eloustaz (MD/MPH)
	Cary T. Grayson (MD/MPH)
	Nicole Jackson (MD/MPH)
	Erica Jones (MD/MPH)
	Jessica Langston (MD/MPH)
	Simon Christopher Lim (MD/MPH)
	Tianming Liu (MD/MPH)
	Daniel Reid (MD/MPH)
	Rebecca Reimers (MD/MPH)
	Lucy Witt (MD/MPH)
	Elliot S. Brannon (MPH/PeaceCorp)
	Kenny L. Wang (MPH)
	Babalola Olayiwola (MPH)
2015	Maeh Al-Shawaf (MPH)
	Nkechi Mbaebie (MPH)
	Oduche Igboechi (MD/MPH)
	Anita Madison (MD/MPH)
	William (Cameron) McGuire (MD/MPH)
	Brigid Avendido (MD/MPH)
	Ngoc Ly (MD/MPH)
2016	Brian Burkett (MD/MPH)

Chad Bush (MD/MPH)
Erin Dawson (MD/MPH)
Brian Duffell (MD/MPH)
Michelle Fleshner (MD/MPH)
Emily Harkins (MD/MPH)
Haley Johnson (MD/MPH)
Jason Ohlstein (MD/MPH)
Stacey Ullman (MD/MPH)
Aktar Faisal (MPH)
Sarah Ali (MPH)

2017 Alexandra Haugh (MD/MPH)
Kelly Jensen (MD/MPH)
Meghan McGwier (MD/MPH)
Shoshana Newman-Gerhardt (MD/MPH)
Hunter Smith (MD/MPH)

2018 Brigid Adviento (MD/MPH)
Christopher Carr (MD/MPH)
Thomas Flowers (MD/MPH)
Zachary Koretz (MD/MPH)
Gregory Minutillo (MD/MPH)
William Preston (MD/MPH)
Christopher Schmitt (MD/MPH)
David Swift (MD/MPH)
Natalie Fortune (MS)

2019 Kionna Henderson (MPH)
Peng Cheng (MPH)

2020 Kyle Arnold (MD/MPH)
Hannah Bernstein (MD/MPH)

Doctoral Dissertation Committees (Member and Chaired)

Dissertation Committees (Chair)

Angela M. Thompson, MPH
PhD in Epidemiology 2012
"Impact of Hurricane Katrina on Medication Adherence and Health Care Facility Utilization among Hypertensive Veterans"
Current Position: Epidemiologist at Centers for Disease Control and Prevention, Atlanta, Georgia

Tian Hu, BM, MPH
PhD in Epidemiology 2015
"Nutritional Factors in the Progression of Chronic Kidney Disease"

Current Position: Post-doctoral fellow at University of Minnesota, School of Public Health, Division of Epidemiology and Community Health, Minneapolis, Minnesota

Ben Pollock, MPH
PhD in Epidemiology 2017
"Cardiovascular Risk Mobility: A Novel Application of Economic Theory to Characterize Life Course Cardiovascular Risk"
Current Position: Epidemiologist, Mayo Clinic, Jacksonville, Florida

Patrick Stuchlik, MS
PhD in Epidemiology 2018
"Childhood and Young Adult Predictors of Cognitive Function in Middle Age: Evidence from the Bogalusa Heart Study"
Current Position: Post-doctoral Fellow, University of California San Francisco, San Francisco, California

Dissertation Committee (Member)

Tanika Kelly, MPH 2008
PhD in Epidemiology: Chair, Jiang He, MD, PhD
"Genetic Variants and the Salt-Sensitivity of Blood Pressure in the Genetic Epidemiology Network of Salt-Sensitivity"
Current Position: Associate Professor of Epidemiology, Tulane University SPHTM

Angela Shen, MPH 2011
Executive ScD in Health Systems Management: Chair, Mahmud Khan, PhD
"An Economic Evaluation for the Introduction of a Future HIV Vaccine"
Current Position: Affiliate Faculty, Drexel University, Dornsife School of Public Health, Consultant - Vaccines and Immunizations, Captain (retired) US Public Health Service

Christopher Anderson, MPH, Expected 2020
PhD in Epidemiology: Chair, Jeanette Gustat, PhD
"The Built Environment, Health Contexts and Health States in the Bogalusa Heart Study Population"

Xiang Li, MPH Expected 2020
PhD in Epidemiology: Chair, Lu Qi, MD, PhD

Jovia Nierenberg, MPH Expected 2020
PhD in Epidemiology: Chair, Tanika Kelly, PhD

PUBLICATIONS

Peer-reviewed Publications

1. He J, Ogden LG, Vupputuri S, **Bazzano LA**, Loria C, Whelton PK. Dietary sodium intake and subsequent risk of cardiovascular diseases in overweight U.S. men and women. JAMA. 1999; 282:2027-2034.

2. He J, **Bazzano LA**. Effects of lifestyle modification on treatment and prevention of hypertension. Current Opinion in Nephrology and Hypertension. 2000; 9:267-271.

3. He J, Ogden LG, **Bazzano LA**, Vupputuri S**,** Loria C, Whelton PK. Risk factors for congestive heart failure in US men and women: NHANES I Epidemiologic Follow-up Study. Arch Intern Med. 2001;161:996-1002

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5. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Dietary potassium intake and risk of stroke in US men and women: NHANES I Epidemiologic Follow-up Study. Stroke. 2001; 32:1473-1480.

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10. He J, Ogden LG, **Bazzano LA**, Vupputuri S, Loria C, Whelton PK. Dietary sodium intake and incidence of congestive heart failure in overweight US men and women: First National Health and Nutrition Examination Survey Epidemiologic Follow-up Study. Arch Intern Med. 2002; 162:1619-1624.

11. **Bazzano LA**, He J, Muntner P, Vupputuri S, Whelton PK. Relationship between cigarette smoking and novel risk factors for cardiovascular disease in the United States. Ann Intern Med. 2003; 138:891–897.

12. **Bazzano LA**, Serdula MK, Liu S. Dietary intake of fruits and vegetables and risk of cardiovascular disease. Curr Atheroscler Rep. 2003; 5: 492-499.

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15. Vupputuri S, Batuman V, Muntner P, **Bazzano LA**, Lefante JJ, Whelton PK, He J. Effect of blood pressure on early decline in kidney function among hypertensive men. Hypertension. 2003; 42:1144-1149.

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88. Chukwurah QC**, Bazzano L**. Body types and association with depressive symptoms among older adults: Findings from NHANES 2013-2016. Innovation in Aging. 2019 Nov;3(Suppl 1): S270.

89. Razavi AC, Fernandez Alonso C, Kelly TN, He J, Potts KS, Whelton SP, **Bazzano LA**. Pooled Cohort Equations-Derived Heart Failure Risk Score Predicts Cardiovascular and all-cause mortality in US adults: The NHANES III Follow-Up Study. Circulation. 2019 Nov 19; 140 (Suppl_1): A17113-.

90. Razavi AC, Wong ND, Budoff MJ, **Bazzano LA**, Kelly TN, He J, Fernandez Alonso C, Lima JA, Polak JF, Mongraw-Chaffin ML, Szklo M. Predictors of Healthy Arterial Aging in Persons with metabolic syndrome and diabetes: The Multi-Ethnic Study of Atherosclerosis. Circulation. 2019 Nov 19; 140 (Suppl_1): A15034.

91. Fernandez C, Razavi A, Barshop R, Guo Y, **Bazzano LA**. Life course determinants of adult diastolic function: Insights from the Bogalusa Heart Study. Circulation. 2019 Nov 19; 140 (Suppl_1): A17257.

92. Guo Y, Fernandez C, Razavi A, Barshop R, **Bazzano LA**. Impact of excessive birth weight on body Mass Index Growth Trajectories Over the Life Course: The Bogalusa Heart Study. Circulation. 2019 Nov 19;140(Suppl_1): A17241.

93. Razavi AC, Fernandez C, **Bazzano LA**, He J, Krousel-Wood MA, Nierenberg J, Shi M, Li C, Mi X, Li S, Kinchen J. Abstract P1125: Serum Metabolite 1-Methylhistidine, a Marker of Red Meat and Poultry Consumption, Independently Associates With Increases in Systolic and Diastolic Blood Pressure in Middle-Aged Adults. Hypertension. 2019 Sep; 74(Suppl_1): AP1125.

Other - Doctoral Dissertation

Bazzano LA. Diet and the Risk of Cardiovascular Disease among U.S. Adults. Tulane University School of Public Health and Tropical Medicine, New Orleans, LA. Doctor of Philosophy, 2000.

PRESENTATIONS

Invited Presentations and Workshops

1. "A Big-Picture Snapshot of Pasta and its Partners on the Plate". Invited presentation: Nutrition Science, Pasta Meals, and the Healthy Mediterranean Diet. Oldways Preservation Trust, Rome, Italy. February 16-18, 2004.

2. "Health Effects of Fruits and Vegetables on Risk of CVD and Diabetes". Invited presentation: Joint World Health Organization-Food and Agriculture Organization Workshop on Fruits and Vegetables, Kobe, Japan. June 23-25, 2004.

3. "Health Aspects of Vegetables and Fruits: Scientific Evidence for 5-a-day". Invited presentation: 10th Annual Karlsruhe Nutrition Congress, Karlsruhe, Germany. October 15-17, 2006.

4. "Micronutrients in Cardiovascular Disease: Current Recommendations". Invited presentation: 48th Annual Meeting of the American College of Nutrition, Orlando, FL. September 27-30, 2007.

5. "Epidemiological Evidence for the Effects of Fruits and Vegetables on Cardiovascular Disease and Diabetes". Seminar presented to faculty and staff of Pennington Biomedical Research Center, Baton Rouge, LA, May 9, 2007.

6. "Folic Acid Supplementation: A Tale of Two Studies" Invited presentation: Internal Medicine Grand Rounds, Tulane University Department of Medicine, New Orleans, LA, January 30th, 2008.

7. "Folic Acid Supplementation and Cardiovascular Disease: State of the Art Update." Invited presentation: Southern Regional Meetings, New Orleans, LA, February 12-14, 2009.

8. "Folic Acid Supplementation in Cardiovascular Disease" Invited presentation: Cardiology Grand Rounds, Tulane University Department of Medicine, Division of Cardiology, New Orleans, LA, March 4, 2009.

9. "What's New in the Art and Science of Teaching Evidence-based Medicine (EBM)?: A 2008 Update for Teachers of EBM". Workshop presented at the 32nd Annual Meeting of the Society of General Internal Medicine, Miami Beach, FL, May 15, 2009. CME Offered

10. "Folic Acid Intervention Studies". Invited Presentation: Max-Rubner Institute Conference, Karlsruhe, Germany. October 11-13, 2009.

11. "Trials of Folic Acid Supplementation in Cardiovascular Disease". Invited Presentation: China Heart Congress and International Heart Forum, Beijing, China. August 12-15, 2010.

12. "Low Carbohydrate Diet and Cardiovascular Disease Risk Factors". Seminar presented to faculty and staff of Pennington Biomedical Research Center, Baton Rouge, LA, May 24, 2012.

13. "Management of Cardiovascular Disease Risk Post-MI and in my Chest Pain (Rule Out) Patients". Invited Presentation: 13th Annual Southern Hospital Medicine Conference, Atlanta, GA. October 24-27, 2012.

14. "Management of Acute Hypertension in the Hospital" Invited Presentation: 14th Annual Southern Hospital Medicine Conference, New Orleans, LA. November 7-9th, 2013.

15. "Fat Is Not the Enemy: Why High Fat Diets May Be Good for Your Waistline and Your Heart" Invited Presentation: Distinguished Lecture Health Sciences Research Day, Tulane University, New Orleans, LA, March 26th, 2015.

16. "Low Carbohydrate Diets, Weight Loss and Heart Health" Invited Presentation: Rutgers University Department of Nutrition. New Brunswick, NJ. April 16th, 2015.

17. "Overview of the Bogalusa Heart Study and Recent Results" Invited Presentation: University of Alabama Birmingham, Department of Epidemiology. Birmingham, AL. May 6th, 2015.

18. Moderator, American Heart Association Epidemiology Conference, Life-course Epidemiology Session, Thursday, March 22nd, 2018, New Orleans, LA.

CURRENT RESEARCH GRANT PARTICIPATION

Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**PROmote weight loss in obese PAD patients to preVEnt mobility loss: the PROVE Trial**
Period of Support:	04/01/2019- 03/31/2024
Funding Source:	NIH/NHLBI (UG3HL141729)
Funding Level:	$3,019,993
Principal Investigator:	Mary McGrae McDermott, MD
Objectives:	The proposed study will randomize 212 participants with peripheral arterial disease (PAD) and BMI > 28 kg/m^2 to one of two groups: weight loss + exercise (WL+EX) vs. exercise alone (EX). Participants will be randomized at three field centers: Northwestern University, University of Minnesota, and Tulane. Our primary outcome is change in six-minute walk distance at 12-month follow-up. Secondary outcomes are change in six-minute walk distance at 6-month follow-up, walking exercise adherence, and change in physical activity, patient-reported walking ability (measured by the Walking Impairment Questionnaire), and quality of life (measured by the SF12 Physical Component Score).

Role:	Principal Investigator
Project:	**Lifespan Cardiovascular Risk Exposures and Alzheimer-related Brain Health: The Bogalusa Heart Study**
Period of Support:	07/01/2019-06/30/2024
Funding Source:	NIH/NIA (2R01AG041200)
Funding Level:	$3,715,021.00
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Owen Carmichael, PhD
Objectives:	The proposed study will examine how cardiovascular risk factors (CVRF) and cumulative exposure to CVRF across the life-course influence Alzheimer-related indicators of brain health including performance on a standardized neurocognitive battery, transcranial doppler ultrasound, cerebral blood flow and oxygenation, 3T brain MRI and, in a subset, amyloid PET scanning, among participants in the Bogalusa Heart Study.

Role:	Principal Investigator
Project:	**Early Life Glycemic Status and Alzheimer's Disease Neuroimaging Markers in Middle Age: The Bogalusa Heart Study**
Period of Support:	12/01/2018-11/30/2023
Funding Source:	NIH/NIA (R01AG062309)
Funding Level:	$3,608,663
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Owen Carmichael, PhD
Objectives:	This project will use neuroimaging and cognitive testing to explore long-term cognitive outcomes among Bogalusa Heart Study participants associated with high-normal early-life mean fasting plasma glucose, as well as Alzheimer's Disease-related neurobiological substrates for these outcomes in a subset of participants will also undergo 3T brain MRI and amyloid PET.
Role:	Principal Investigator

Project:	**A Novel Research Infrastructure Enabling Life-course Studies of Healthy Aging**
Period of Support:	08/15/2018-07/31/2023
Funding Source:	NIH/NIA R21/R33 Phased Innovation Award (R21AG057983)
Funding Level:	$2,743,499
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Elaine Urbina, Jessica Woo
Objectives:	The overall objective of this proposal is to develop and enhance a novel research infrastructure that will advance the science of aging in the area of early life and childhood protective factors that contribute to "successful" aging. In the R21 phase, we will catalog and consolidate biorepositories across three cohorts, and in the R33 phase, we will demonstrate the feasibility of remote measurement methods.

Role:	Principal Investigator
Project:	**The Role of Vascular Aging in Cognitive and Physical Function**
Period of Support:	09/01/2012-11/30/2018 No Cost Extension
Funding Source:	NIA (R01AG041200)
Funding Level:	$ 2,399,927
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	This project will examine the role of vascular aging, lifestyle and diet in maintenance of cognitive and physical performance by recruiting 1,257 participants in the Bogalusa Heart Study who will undergo cognitive function, physical function and cardiovascular risk factor examination at baseline and again 2 years later at follow- up.

Role:	Principal Investigator
Project:	**A tRial of the idEal proteiN systEm versus loW fAt diet for weight Loss: RENEWAL**
Period of Support:	01/01/2018-12/31/2019
Funding Source:	Ideal Protein of America, Inc.
Funding Level:	$432,125

Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	RENEWAL is a randomized controlled clinical trial examining the effects of a restricted carbohydrate, optimal protein (Ideal Protein) diet as compared to a guideline-based, low-fat, restricted calorie diet on changes in body weight, composition, traditional and CVD risk factors.

Role:	Co-Investigator
Project:	**Tulane Building Interdisciplinary Research Careers in Women's Health (BIRCHW)**
Period of Support:	09/26/2002-07/31/2023
Funding Source:	NIH/ K12HD043451
Funding Level:	$2,693,710
Principal Investigator:	Marie Krousel-Wood, MD
Objectives:	The Tulane BIRCWH Program provides mentored career development for junior faculty to increase the number of highly trained independent investigators in sex/ gender differences and women's health in the field of cardiovascular and related diseases.

Role:	Co-Investigator (Subcontract from Children's Hospital Medical Center)
Project:	**Childhood CV Risk and Adult CVD Outcomes: an International Long-term Follow-up**
Period of Support:	12/01/2014-11/30/2019
Funding Source:	NIH/NHLBI (R01HL121230)
Funding Level:	$10,561,912
Principal Investigator:	Jessica Woo, PhD
Objectives:	This research is a multicenter study of international longitudinal cohort studies (Bogalusa, Louisiana; Minneapolis, Minnesota; Muscatine, Iowa; Cincinnati, Ohio; Princeton, Ohio; Australia and Finland). The study leverages the existing collaborative structure to assess the relation of childhood and adolescent cardiovascular risk factors to adult endpoints.

Role:	Co-Investigator
Project:	**Tulane COBRE for Clinical and Translational Research in Cardiometabolic Diseases**
Period of Support:	03/10/2016-02/28/2021
Funding Source:	NIH/NIGM (P20GM109036)
Funding Level:	$13,330,930
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The overall objective of this COBRE application is to increase the quality and quantity of clinical, translational and implementation research in cardiometabolic diseases at Tulane University. Role:

Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**Improve PAD Performance with Metformin: The PERMET Trial**
Period of Support:	03/01/2018-11/30/2019
Funding Source:	NIH/NHLBI (R01HL131771)
Funding Level:	$2,974,184

Principal Investigator:	Mary McGrae McDermott
Objectives:	The PERMET trial is a placebo controlled double-blind randomized clinical trial to establish whether metformin (2,000 mgs daily) improves and/or prevents decline in walking performance in people with peripheral artery disease (PAD).
Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**TELmisartan plus EXercise to improve functioning in PAD: The TELEX Trial**
Period of Support:	03/01/2018-04/30/2019
Funding Source:	NIH/NHLBI (R01HL126117)
Funding Level:	$2,933,532
Principal Investigator:	Mary McGrae McDermott
Objectives:	TELEX is a randomized controlled clinical trial designed to establish whether telmisartan improves walking performance in people with peripheral artery disease (PAD). The TELEX trial will also determine whether telmisartan plus supervised exercise improves walking performance more than either therapy alone.
Role:	Co-investigator
Project:	**The Roles of the Microbiome and Metabolome in Vascular Aging**
Period of Support:	09/01/2016-05/31/2019 (NCE)
Funding Source:	NIH/NIA (R21AG051914)
Funding Level:	$263,375
Principal Investigator:	Tanika Kelly, PhD
Objectives: vascular	To identify gut bacterial communities and metabolites influencing aging among 300 Bogalusa Heart Study participants. These findings may also be used to advance clinical and public health practice through the development of novel therapies for CVD and promotion of healthy aging.

PAST RESEARCH GRANT PARTICIPATION

Role:	Principal Investigator
Project:	**Lifespan Cardiovascular Exposures and Risk of Brain Injury in the Bogalusa Heart Study**
Period of Support:	1/01/2017 – 12/31/2018
Funding Source:	Louisiana Clinical and Translational Science Center - Pilot Project
Funding Level:	$50,000
Principal Investigator:	Lydia Bazzano, MD, PhD
Objectives:	The goals of this project are to collect 3TMRI measures of brain health from members of the Bogalusa Heart Study, and to assess relationships between lifespan exposures to cardiovascular risk
Role:	Co-Investigator

Project:	**Linking Health and Environmental Outcomes to Dietary Behaviours in the United States**
Period of Support:	10/01/2015-08/31/2017
Funding Source:	Wellcome Trust (106854/Z/15/Z)
Funding Level:	$624,997
Principal Investigator:	Diego Rose, PhD
Objectives:	The project aims to improve our understanding of how dietary choices influence health and environmental outcomes, and how such choices can be modified through public policy.

Role:	Co-Investigator (Subcontract via Louisiana Public Health Institute)
Project:	**PCORnet Bariatric Study**
Period of Support:	10/01/2015-09/30/2017
Funding Source:	PCORI OBS150530683
Funding Level:	$4,568,390
Principal Investigator:	David Arterburn, MD, MPH
Objectives:	The main goal of this comparative effectiveness research study is to provide accurate estimates of the 1-, 3-, and 5-year benefits and risks of the three main surgical treatment options for severe obesity.

Role:	Co-Investigator
Project:	**Long-Term Burden of Maternal Cardiovascular Risk Factors and Birth Outcomes**
Period of Support:	08/05/2012-06/30/2017
Funding Source:	NIH/NICHD (R01HD069587)
Funding Level:	$1,538,429
Principal Investigator:	Emily Harville, PhD
Objectives:	The overall objective with this project is to determine the relationship between pre-pregnancy cardiovascular risk, from childhood through early adulthood, and birth outcomes.

Role:	Co-Investigator
Project:	**Childhood Secondhand Smoke and Longitudinal Cardiovascular Risk Profile**
Period of Support:	09/17/2012-06/30/2015
Funding Source:	NIEHS (R01ES021724)
Funding Level:	$1,203,299
Principal Investigator:	Wei Chen, MD, PhD
Objectives:	The major goal is to study childhood secondhand smoke exposure and its impact on cardiovascular disease risk from childhood to adulthood within a black-white population using a longitudinal cohort.

Role:	Subcontract, Co-Investigator
Project:	**South American Center of Excellence in Cardiovascular Health**
Period of Support:	06/08/2009-06/07/2014
Funding Source:	NHLBI (HHSN268200900029C)
Funding Level:	$5,270,206

Principal Investigator:	Adolpho Rubenstein, MD
Objectives:	The objective of the South American Center of Excellence in Cardiovascular Health (SACECH) is to establish a cohort in the Southern Cone of Latin America in order to (1) estimate the prevalence, distribution, and secular trend of major CVD and risk factors in the Southern Cone, (2) examine the association between traditional and novel CVD risk factors and incidence, (3) assess the burden of CVD, and (4) identify future interventions

Role:	Co-Investigator
Project:	**Clinical Center for Prospective Cohort Study of CRI**
Period of Support:	09/28/2001-04/30/2013
Funding Source:	NIDDK (U01DK060963)
Funding Level:	$4,402,718
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The major goals of this project are to examine risk factors for the progression of renal disease and development of cardiovascular disease in patients with chronic renal insufficiency.

Role:	Co-Investigator
Project:	**Research Training in Gene-Environment Interaction in China**
Period of support:	07/01/2012─06/30/2017
Funding source:	Fogarty International Center (D43 TW009107)
Funding level:	$1,343,470
Principal Investigator:	Jiang He, MD, PhD
Objectives:	This joint training program of the Tulane University and Tropical Medicine and the Chinese Academy of Medical Sciences and Peking Union Medical College, and the National Center for Cardiovascular Diseases of China aimed to provide research training in gene-environment interaction in chronic diseases across the lifespan in China.

Role:	Co-Investigator
Project:	**Comprehensive Approach for Hypertension Prevention and Control in Argentina**
Period of support:	04/01/2012 –03/31/2017
Funding source:	NHLBI (1U01HL114197-01)
Funding level:	$2,218,017
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The overall objectives of the proposed cluster randomized trial are to test whether a comprehensive intervention program within a national public primary care system will improve hypertension prevention and control among uninsured hypertensive patients and their families in Argentina.

Role:	Principal Investigator
Project:	**Heritability and Genome-wide Linkage of Lipid Phenotypes**
Period of Support:	09/15/2008-06/30/2012
Funding Source:	NHLBI (K08HL091108)

Funding Level:	$458,800
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	The overall objectives of the proposed study are to investigate familial correlations, heritability, and major gene effects for serum lipid and lipoprotein phenotypes and investigate the role of quantitative trait loci by conducting genome-wide linkage analyses using 407 microsatellite markers.

Role:	Junior Faculty Investigator
Project:	**Tulane COBRE in Hypertension and Renal Biology**
Period of Support:	09/2007-08/2012
Funding Source:	NCRR (P20RR017659)
Funding Level:	$12 million
Principal Investigator:	Louis Gabriel Navar, PhD
Objectives:	The objectives are to provide an enriched mentoring environment to junior faculty investigators so that they can achieve independent status and national competitiveness and to augment and strengthen biomedical research capacity at Tulane University Health Sciences Center and the State of Louisiana in hypertension and associated renal and cardiovascular disease.

Role:	Co-Investigator
Project:	**Sodium Sensitivity and Risk of Hypertension**
Period of Support:	07/01/2007-07/31/2012
Funding Source:	NHLBI (R01HL087263)
Funding Level:	$2,834,971
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The major objectives are to examine the relationship between blood pressure responses to dietary sodium and the risk of hypertension and to examine the association between biological candidate genes and the risk of hypertension.

Role:	Principal Investigator
Project:	**Impact of Hurricane Katrina on Medication Adherence and Health Care Facility Utilization among Veterans**
Period of Support:	11/15/2006-11/15/2011
Funding Source:	Tulane University Research Enhancement Fund-Phase II
Funding Level:	$45,000
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	This project evaluates adherence of hypertensive veterans to medication regimens and use of health care facilities before and after Hurricane Katrina

Role:	Primary Care Physician
Project:	**Primary Care Access Stabilization Grant**
Period of Support:	09/2007-09/2010
Funding Source:	Louisiana Public Health Institute

Funding Level:	$1,962,232
Principal Investigator:	L. Lee Hamm, MD
Objectives:	The objective of this project is to restore and expand access to primary care in the greater New Orleans area in the wake of Hurricane Katrina and its aftermath.

Role:	Co-Principal Investigator
Project:	**Comparison of Efficacy and Safety of NPH Insulin and Glargine Insulin**
Period of Support:	03/15/2007-06/15/2007
Funding Source:	Eli Lilly & Co.
Funding Level:	$22,452
Principal Investigator:	Lydia A. Bazzano, MD, PhD and Lizheng Shi, PharmD, PhD
Objectives:	The major objective of this project is to perform meta-analysis to examine treatment effects, hypoglycemia, glycosylated hemoglobin, weight gain and doses between Neutral Protamine Hagedorn (NPH) insulin and glargine insulin among person with type II diabetes.

Role:	Junior Faculty Scholar
Project:	**Building Interdisciplinary Research Careers in Women's Health**
Period of Support:	07/01/2005-06/30/2007
Funding Source:	ODS/NICHD (K12HD43451)
Funding Level:	$449,993
Principal Investigator:	Paul K. Whelton, MD, MSc.
Objectives:	This grant is designed to promote research and the transfer of research findings to clinical care that will benefit the health of women.

EXHIBIT 9

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

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

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

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system. In making the following statements, I am not commenting on the particular issues posed this case. Rather, I am making general statements about the realities of persons in detention facilities, jails and prisons.

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

5. I was paid $1,000 for my time drafting an earlier version of this report filed in another case. I subsequently prepared this version of the report without receiving payment for my services.

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

II. Heightened Risk of Epidemics in Jails and Prisons

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

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

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

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

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

lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

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

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

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these

[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.

conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

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

III. Profile of COVID-19 as an Infectious Disease[4]

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

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[2] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

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

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

general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily

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

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

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

released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[9] Systems are challenged to respond to COVID-19 guidelines that are modified on a near-daily basis. It may be impossible to adequately respond to the COVID-19 pandemic, while also respecting the rights and dignity of people who are incarcerated.

IV. Possible Risks of COVID-19 in ICE Detention Facilities

25. Based on my experience working on public health in jails and prisons, I can make the following general statements about how the COVID-19 outbreak will interact with and exacerbate conditions that may exist in some detention centers.

26. Any delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

27. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

28. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

29. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

30. Failure to keep accurate and sufficient medical records will make it more difficult for facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

31. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to

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

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

provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

32. Facilities with a track record of neglecting individuals with acute pain and serious health needs under ordinary circumstances are more likely to be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

33. Similarly, facilities with a track record of failing to adequately manage single individuals in need of emergency care are more likely to be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

34. For individuals in facilities that have experienced these problems in the past, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

35. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large. As such, from a public health perspective, it is my recommendation that individuals who can safely and appropriately remain in the community not be placed in ICE detention facilities at this time. I also recommend that individuals who are already in these facilities should be evaluated for release.

36. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65.

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

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

March 23, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

CURRICULUM VITAE

Name: Jaimie P. Meyer, M.D., M.S.

Education:

B.A.	Dartmouth College (Anthropology) 2000
M.D.	University of Connecticut 2005
M.S.	Yale School of Public Health (Biostatistics and Epidemiology) 2014

Career/Academic Appointments:

2005-08	Intern and Resident, Internal Medicine, NY Columbia Presbyterian Hospital, New York, NY
2008-11	Clinical and Research Fellow, Infectious Diseases, Yale University, New Haven, CT
2010-12	Postdoctoral Fellow, Center for Interdisciplinary Research on AIDS, Yale School of Public Health, New Haven, CT
2012-14	Instructor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2014-present	Assistant Professor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2015-present	Clinical Assistant Professor, Division of Primary Care/Health Systems in Nursing, Yale School of Nursing, New Haven, CT

Clinical Positions Held & Other Employment:

1999	Spanish Medical Interpreter, Boston Children's Hospital, Boston, MA
2000-01	Research Assistant, UCSF Immunogenetics and Transplantation Laboratory, San Francisco, CA
2010-12	Infectious Diseases Attending (per diem), Hospital of Saint Raphael, New Haven, CT
2009-15	Infectious Diseases Clinician, York Women's Correctional Institution, Niantic, CT
2015-	HIV Clinician, Nathan Smith Clinic, New Haven, CT
2018-	Faculty, Contemporary Management of HIV, Clinical Care Options

Board and other Certifications:

American Board of Internal Medicine, Internal Medicine, 2008, 2018
American Board of Internal Medicine, Infectious Diseases, 2010
American Board of Preventive Medicine, Addiction Medicine, 2018
DATA 2000 DEA X waiver to prescribe Buprenorphine, 2010
REMS Certified implanter and prescriber for Probuphine, 2016

Professional Honors & Recognition

A) <u>International/National/Regional</u>

2018	Selected as Early Career Reviewer, NIH Center for Scientific Review
2017	Doris Duke Charitable Foundation Scholar

2016 Fellow, American College of Physicians
2016 NIH Health Disparities Loan Repayment Award Competitive Renewal
2016 Selected for AAMC Early Career Women Faculty Professional Development Seminar
2014 NIH Health Disparities Loan Repayment Program Award
2014 NIDA Women & Sex/Gender Differences Junior Investigator Travel Award
2014 International Women's/Children's Health & Gender Working Group Travel Award
2014 Patterson Trust Awards Program in Clinical Research
2013 Thornton Award for Clinical Research
2011 Bristol Myers-Squibb Virology Fellows Award
2006 John N. Loeb Intern Award
2005 Connecticut State Medical Society Award
2005 American Medical Women's Association Citation
2000 Hannah Croasdale Senior Award, Dartmouth College
1998 Palaeopitus Senior Leadership Society Inductee, Dartmouth College

B) University
2014 Fellow, Women's Faculty Forum Public Voices Thought Leadership Program

PROFESSIONAL SERVICE

Journal Service:
Reviewer
2012-present (In alphabetical order): *Addiction Sci and Clin Pract, Addictive Behav Reports, AIDS Care, AIMS Public Health, American Journal on Addictions, American Journal of Epidemiology, American Journal of Public Health, Annals Internal Medicine, BMC Emergency Medicine, BMC Infectious Diseases, BMC Public Health, BMC Women's Health, Clinical Infectious Diseases, Critical Public Health, Drug and Alcohol Dependence, Drug and Alcohol Review, Epidemiologic Reviews, Eurosurveillance, Health and Justice (Springer Open), International Journal of Drug Policy, International Journal of Prisoner Health, International Journal of STDs and AIDS, International Journal of Women's Health, JAIDS, JAMA Internal Medicine, Journal of Family Violence, Journal of General Internal Medicine, Journal of Immigrant and Minority Health, Journal of International AIDS Society, Journal of Psychoactive Drugs, Journal of Urban Health, Journal of Women's Health, Open Forum Infectious Diseases, PLoS ONE, Public Health Reports, University of Wisconsin-Milwaukee Research Growth Initiative, Social Science and Medicine, SpringerPlus, Substance Abuse Treatment Prevention and Policy, Women's Health Issues, Yale Journal of Biology and Medicine*

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

Grant Service:
Reviewer:
2020 Doris Duke Charitable Foundation Physician Scientist Fellowship Award
2019 NIH RFA-DA-19-025 HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers

Professional Service for Professional Organizations

2016-present Fellow, American College of Physicians

2016-present Member, AAMC Group on Women in Medicine and Science (GWIMS)
2013-2016 Member, American College of Physicians
2013-present Member, InWomen's Network, NIDA International Program
2011-present Member, American Medical Women's Association
2011-present Member, Connecticut Infectious Disease Society
2009-present Member, American Society of Addiction Medicine
2008-present Member, Infectious Disease Society of America
2005-present Member, American Medical Association
2005-2008 Member, New York State Medical Society

Yale University Service

2019-present Core Faculty, Program in Addiction Medicine
2017-present Affiliated Faculty, Arthur Liman Center for Public Interest Law, Yale Law School
2016-present Leadership Council, Women's Faculty Forum, Yale University
2015-2016 Steering Committee, US Health and Justice Course, Yale School of Medicine
2014-present Yale Internal Medicine Traditional Residency Intern Selection Committee
2013-present Women in Medicine at Yale Mentoring Program
2013-present Women in Science at Yale Mentoring Program
2012-present Affiliated Scientist, Center for Interdisciplinary Research on AIDS
2009-2011 Preclinical Clerkship Tutor, Yale School of Medicine

Individual Mentorship
2020 Zoe Sernyak, Yale University: Summer internship
2020 Caroline Wortman, Cornell University: Summer internship
2020 Chevaughn Wellington, Quinnipiac School of Medicine: Capstone Project Advisor
2019 Callie Ginapp, Yale School of Medicine: Research Mentor
2019 Alissa Haas, Yale School of Public Health (EMD): Research mentor
2019 Emily Bail, Yale School of Nursing: APRN Clinical mentor
2018 Camila Odio, Yale Internal Medicine Residency Program: Research mentor
2018 Zoe Adams, Yale School of Medicine: Research mentor
2018 Yilu Qin, Yale Primary Care Residency Program, HIV Training Track: Research mentor
2018 Kaitlin Erickson, Yale School of Nursing: APRN Clinical mentor
2017-2019 Emily Hoff, Yale School of Medicine: Research mentor, Thesis mentor
2017 Lindsay Eysenbach, Yale School of Medicine: Research mentor, Summer project on Syringe Service Program
2017 Megan Carroll, Yale School of Public Health: M.S. Thesis advisor (Biostatistics)
2016-2020 Britton Gibson, Yale School of Public Health and Quinnipiac School of Medicine: Research mentor
2016 Ronnye Rutledge, Yale School of Medicine: MHS Thesis advisor; awarded IDSA Education and Research Foundation 2015 Medical Scholarship and Yale School of Medicine Medical Student Research Fellowship; earned School and Departmental Honors for Thesis
2015 Kelsey Loeliger, Yale Schools of Medicine and Public Health: M.D./Ph.D. Dissertation committee

2014 Javier Cepeda, Yale School of Public Health: Ph.D. Research advisor/mentor
2014 Audrey Fritzinger, Yale PA Program: Thesis advisor; Received Honors for thesis
2014 Cecilia Dumouchel, Yale College: Summer internship
2014 Joan Chi-How, Yale School of Medicine: Internship
2014 Michelle Fikrig, Oberlin College: Summer internship
2014 Madison Breuer, Southern Connecticut State University: Internship

Public Service

2020 Expert Consultant on COVID-19 Preparedness in Vermont Department of Corrections: Vermont Office of the Defender General, Prisoner Rights' Office
2020 Expert Consultant on COVID-19 in Jails and Prisons: New York ACLU and Bronx Defenders, *Onosamba-Ohindo, et al. v. Barr et al., Case No. 20-cv-0290 (W.D.N.Y.).*
2020 Expert Consultant on COVID-19 in Jails and Prisons: New York ACLU and Bronx Defenders, *Velesaca v. Wolf et al., Case No. 20-cv-1803 (S.D.N.Y.).*
2019 Consultant on Medication Assisted Treatment in Prisons, Vermont Department of Corrections, Addiction Health Services
2019 Expert Witness for Women in Prison Briefing, U.S. Commission on Civil Rights
2018 Consultant for SAMHSA State Targeted Response-Technical Assistance Consortium to address the opioid crisis, American Academy of Addiction Psychiatry
2017 Consultant on HIV Care in Prisons, United Nations Office on Drugs and Crime
2017 Scientific Advisory Board, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.
2016 Consultant on Women's Health, Female Offenders Unit, Federal Bureau of Prisons
2002 "Medicine as a Profession" Fellow, Soros Open Society Institute
1999 Volunteer Spanish Medical Interpreter, Boston Children's Hospital
1998 Honorary Service Fellow, Costa Rican Humanitarian Foundation

Research Support

Ongoing Research Support

ACTIVE
Investigator Sponsored Award (M161462) PI: Meyer 7/1/2017-6/30/2020 1.8 calendar
Gilead Sciences, Inc. $81,151 (FY1 Directs)
Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Description: To leverage risk networks of CJ-involved women as a means of delivering PrEP and to evaluate the acceptability and feasibility of strategically delivering PrEP to network members.

Clinical Scientist Development Award PI: Meyer 7/1/17-6/30/20 3.0 calendar
Doris Duke Clinical Foundation $149,959 (FY1 Directs)

Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Description: 1) To adapt a patient-centered HIV prevention decision aid to women with substance use entering treatment for substance use disorders. 2) Building on findings from Aim 1, to pilot test the effect of the adapted decision-aid intervention on PrEP uptake among women with substance use entering treatment for substance use disorders.

1 R21 DA042702-01A1 PI: Meyer 8/1/2017–7/31/2020 (NCE) 1.20 calendar
NIH/NIDA $129,673 (FY1 Directs)
Prisons, Drug Injection and the HIV Risk Environment in Kyrgyzstan
Description: We propose to generate qualitative data from interviews with prisoners and prison staff and triangulate it with quantitative data from MATLINK within an analytical HIV risk environment framework which aims to: 1. Describe the individual-environment interactions that shape within-prison drug-related HIV risk practices and health expectations post-release; and 2. Measure how within-prison risk and other factors within the prison environment mediate engagement with OAT both within prison and after release.

H79 TI080561 PI: Meyer 11/30/2018–11/29/2023 1.20 calendar
SAMHSA $389,054 (FY1 Directs)
CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
We will expand and enhance the local implementation of a community infrastructure that integrates housing, behavioral health, and addiction treatment services for highly vulnerable populations at-risk for or living with HIV (PARLWH), by virtue of their involvement in criminal justice (CJ) systems and/or engagement in sex work. The target population for CHANGE is CJ-involved PARLWH in New Haven, Connecticut who experience co-occurring homelessness, psychiatric, and substance use disorders.

Pilot Project Award mPI: Willie, Meyer 10/01/19-09/30/20 0.24 calendar
Center for Interdisciplinary Research on AIDS (CIRA) $29,993
Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
This Type II hybrid effectiveness-implementation study seeks to adapt an existing PrEP decision aid to intimate partner violence (IPV)-exposed women seeking domestic violence services at two major Connecticut service agencies. This study will: provide support for a PrEP decision aid that addresses the HIV prevention needs of IPV-exposed women; use implementation science to increase PrEP uptake; include DV agencies in intervention development and implementation; and improve understanding of PrEP scale-up by addressing implementation factors in the community settings that serve IPV-exposed women.

R01 MH121991 mPI: Meyer, Sullivan 01/01/2020-11/30/2024 1.8 calendar
NIMH $374,816 (FY1 Directs)
Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
The main purpose of this study is to understand how exposure to intimate partner violence (IPV) affects women's abilities to self-manage their HIV on a daily basis (i.e., adhere to antiretroviral medication), engage in longitudinal HIV care, and achieve and

sustain viral suppression. The project aims to build awareness of the IPV-health association and inform strategies/resources to promote resilience.

UNDER REVIEW:
R01 MH124533 PI: Meyer 07/01/2020-06/30/2025 3.6 calendar
NIMH $577,894 (FY1 Directs)
TelePrEP+ for Women in Criminal Justice Systems
This study is designed to test an active facilitation strategy (ePrEP) for scaling up PrEP, an evidence-based practice, in two distinct settings (Connecticut and Alabama) for a key population of women involved in criminal justice systems. We will randomize justice-involved, PrEP-eligible women across two sites (CT and AL) to receive ePrEP or standard of care. Using a Type I Hybrid Efficacy-Implementation framework, we will evaluate individual-level (PrEP initiation and 6-month retention) and organizational-level outcomes important for ePrEP scalability and sustainability across diverse contexts.

Inmate Health Services 2019 (Clinical Services Contract) PI: Meyer
10/01/2019-09/30/2022 0.96
Connecticut Department of Corrections $436,899
Yale Center of Excellence in Prison Health
We will create a Yale Center of Excellence in Prison Health that will provide specialty e-consultation, staff development, and quality assurance programs for the CT Department of Correction (DOC) in the areas of Behavioral Health, Transitional care, and Infectious Diseases, which are the largest cost centers for DOC healthcare. We will additionally provide outpatient specialty telehealth services in key areas, including: Cardiology, Endocrinology, and Rheumatology. We focus on regional healthcare delivery (RFPs 2 and 4), acknowledging that the majority of people in these facilities will return home to the greater New Haven area, enabling continuity of care and serving as a regional hub.

Inmate Health Services 2019 (Clinical Services Contract) PI: Meyer
10/01/2019-09/30/2022 0.96
Connecticut Department of Corrections $250,805
Yale HIV in Jails Program
The current proposal seeks to reinvigorate and improve upon the HIV in Prisons Program to deliver high quality, cost-effective HIV care and Infectious Disease consultations to PWH in each of Connecticut's jails (Hartford CC in RFP Region 1; New Haven CC in RFP Region 2; Bridgeport CC in RFP Region 3; Corrigan Radgowski CC and York CI in RFP Region 4).

Completed Research Support
K23 DA033858 PI: Meyer 7/1/2012 – 11/30/2017 9.0 calendar
NIH/NIDA $153,529 (FY1 Directs)
Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
The major goal of this project is to inform, adapt and test an intervention that will improve HIV treatment outcomes for community-based women who interface with the criminal justice system, either after release from jail or during community supervision.

Patterson Trust Awards Program in Clinical Research PI: Meyer 1/31/14-10/30/15

Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes

Bristol Myers-Squibb HIV Virology Fellowship Award PI: Meyer 9/1/11-6/30/13

NIMH T32 MH020031 PI: Ickovics 7/2/10-6/30/12
Interdisciplinary HIV Prevention Training Program, Yale University School of Epidemiology and Public Health, Center for Interdisciplinary Research on AIDS
Role: Research Scientist

NIAID T32 AI007517 PI: Quagliarello 6/30/09-7/1/10
Training in Investigative Infectious Disease, Yale University School of Medicine, Section of Infectious Disease
Role: Research Scientist

Publications

Peer-Reviewed Journals

Azar M, Springer S, **Meyer J,** Altice F. A Systematic Review of the Impact of Alcohol Use Disorders on HIV Treatment Outcomes, Adherence to Antiretroviral Therapy and Health Care Utilization. Drug and Alcohol Dependence 2010, 112: 178–193. *PMID 20705402. PMCID: PMC2997193*

Meyer J, Springer S, Altice F. Substance Abuse, Violence, and HIV in Women: A Literature Review of the SAVA Syndemic. Journal of Women's Health 2011, 20(7). *PMID 21668380. PMCID: PMC3130513*

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Meyer J, Chen N, Springer S. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. AIDS Research and Treatment 2011; 2011:680617. *PMID 21776379. PMCID: PMC3137962*

Springer S, Spaulding A, **Meyer J,** Altice F. Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components. Clinical Infectious Disease 2011; 53(5): 469-479. *PMID 21844030 PMCID: PMC3156144.*

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Meyer J, Qiu J, Chen N, Larkin G, Altice F. Emergency Department Use by Released Prisoners with HIV: An Observational Longitudinal Study. PLoS ONE 2012; 7(8): e42416. *PMID: 22879972 PMCID: 3411742*

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Meyer J, Wickersham J, Fu J, Brown S, Sullivan T, Springer S, Altice F. Partner Violence and Health among HIV-Infected Jail Detainees. International Journal of Prisoner Health 2013; 9(3): 124-141. *DOI: 10.1108/IJPH-03-2013-0011. PMID: 24376468 PMCID: PMC3873166.*

Althoff A, Zelenev A, **Meyer J**, Fu J, Brown S, Vagenas P, Avery A, Cruzado J, Spaulding A, Altice F. Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. AIDS and Behavior 2013 Oct;17 Suppl 2:156-70. *PMID: 23161210. PMCID: 3714328.*

Chen N, **Meyer J**, Avery A, Draine J, Flanigan T, Lincoln T, Spaulding A, Springer S, Altice F. Adherence to HIV Treatment and Care among Previously Homeless Jail Detainees. AIDS Behav. 2013 Oct;17(8):2654-66. doi: 10.1007/s10461-011-0080-2. *PMID: 22065234. PMCID: PMC3325326*

Williams C, Kim S, **Meyer J,** Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Simon D, Wickersham J, Murphy-Swallow D, Ouellet L. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement among HIV-positive Clients Leaving Jail. AIDS and Behavior 2013 Oct;17 Suppl 2:195-202 *PMID: 23314801 PMCID: PMC3758427*

Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of Substance Use Disorders on HIV Treatment Outcomes and Antiretroviral Medication Adherence Among HIV-infected Persons Entering Jail. AIDS and Behavior 2013 Oct;17 Suppl 2:118-27. doi: 10.1007/s10461-013-0506-0 *PMID: 23673792. PMCID: PMC3818019*

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Meyer J, Zelenev A, Wickersham J, Williams C, Teixiera P, Altice F. Gender Disparities in HIV Treatment Outcomes Following Release From Jail: Results From a Multicenter Study. American Journal of Public Health. 2014 Mar; 104(3): 343-41. *NIHMS: 581757. PMID: 24432878. PMC3953795.*

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Boyd A, Song D, **Meyer J**, Altice F. Emergency Department Use among HIV-Infected Released Jail Detainees. J Urban Health. 2014 Oct 21. [Epub ahead of print] *PMID: 25331820. PMC4338130*

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Meyer J, Cepeda J, Taxman F, Altice F. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-infected Inmates. American Journal of Public Health: 2015 Sep;105(9):1901-10. doi: 10.2105/AJPH.2015.302687. Epub 2015 Jul 16. NIHMS677862. PMID: 26180958. PMC4529767

Meyer J, Womack J, Gibson B. Beyond the Pap Smear: Gender-Responsive HIV Care for Women. Yale J Biol Med (Focus Issue: Sex and Gender Health). 2016 Jun; 89(2): 193–203. PMCID: PMC4918880

Bernardo R, Streiter S, Tiberio P, Rodwin B, Mohareb A, Ogbuagu O, Emu B, **Meyer J.** Photo Quiz: A Peripheral Blood Smear in a Ugandan Refugee. Journal of Clinical Microbiology. 2017 December 55(12): 3313-3314.

Peasant C, Sullivan T, Weiss N, Martinez I, **Meyer J.** Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence. AIDS Care. 2016 Sep 2:1-8. PMID: 27590004. PMCID: PMC5291821.

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Harada K, Heaton H., Chen J., Vazquez M, **Meyer J.** Herpes zoster vaccine-associated Primary Varicella Infection in an Immunocompetent Host: Case Report and Literature Review. BMJ Case Rep. 2017 Aug 22;2017. pii: bcr-2017-221166. PMID: 28830902. NIHMS 913803. PMC5624100.

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Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health: *Under revision*.

Qin L, Price C, Puglisi L, Rutledge R, Madden L, **Meyer J.** Women's Decision-Making about PrEP for HIV Prevention in Drug Treatment Contexts. J Int Assoc Provid AIDS Care. 2020;19:2325958219900091. PMID: 31918605

Hoff E, Rutledge R, Gibson B, Price C, Gallagher C, Maurer K, **Meyer J.** PrEP for Women across the Criminal Justice Continuum in Connecticut: Implications for Policy and Practice. J Corr Healthcare: *In press. NIHMS 1573821*

Manuscripts in Submission

Muthulingham D, Clemons T, Marcus R, **Meyer J,** Yonkers K**.** Pregnancy as Peril for Women with Addiction: Public Health, not Punishment. AJPH: *Under review.*

Rich K, Loeliger K, Chandra D, Muthulingam D, Althoff K, Gallagher C, **Meyer J,** Altice F. Elevated Mortality Risk after Release from Prisons and Jails: Implications for Targeting At-Risk Persons. JAIDS: *Under review.*

Rich K, Eysenbach L, Joslin S, Marcus R, Brothers S, **Meyer J,** Altice F. Evaluation of a "One-Stop-Shop": An innovative treatment and prevention program that integrates harm reduction and primary care services for people who inject drugs. J Urban Health*: Under review.*

Barber D, Kempner T, Pasalar S, Borne D, Eysenbach L, Quinn E, Rajabiun S, **Meyer J.** Effects of a Multisite Medical Home Intervention on Emergency Department Use among Homeless People with HIV. J Healthcare Poor and Underserved*: Under review.*

Meyer J, Franco-Paredes C, Parmar P, Yasin F, Gartland M. COVID-19 and the Coming Plague in U.S. Immigration Detention Centers. NEJM: *Under review.*

Manuscripts in Preparation

Meyer J, Flash C, Gonzalez N, Pan A, Yuan Y, Rajabiun S. The Intersecting Effect of Gender and Race on Housing and HIV Outcomes in a Multisite Medical Home Project. *To submit to AJPH.*

Culbert G, Azbel L, Bachireddy C, Kurmanalieva A, Rhodes T, Altice F, **Meyer J**. A Qualitative Study of Diphenhydramine Injecting in Kyrgyz Prisons and Implications for Harm Reduction Efforts. *To submit to Harm Reduction J.*

Hoff E, Adams Z, Hass A, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Needs of Women at Risk of HIV in Connecticut. *To submit to J Women's Health.*

Meyer J, Shrestha R, Shenoi S, Wickersham J, Altice F. Potential and Challenges of Same Day PrEP for Key Populations. *To submit to Lancet HIV.*

Meyer J, Price CR, Tracey D, Madden L, Elwyn G, Altice F. Development and Efficacy of a PrEP Decision Aid for Women in Drug Treatment. *To submit to JSAT.*

Book Chapters

Meyer J, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. *Sexually Transmitted Infections* 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.

Meyer J, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. *Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award).* Oxford University Press 2015. ISBN 9780199360574.

Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J.** Infectious Diseases in Underserved Populations. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. *Current Diagnosis and Treatment- Infectious Diseases*. McGraw-Hill Medical 2016.

Shrestha R, McCoy-Redd B, **Meyer J.** Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. *The Opioid Epidemic and Infectious Diseases.* Elsevier 2019.

Other Publications and Reports

Paul J (maiden surname). Bullous Pemphigoid in a Patient with Psoriasis and Possible Drug Reaction. Connecticut Medicine 2004 Nov-Dec; 68(10):611-5.

Meyer J *for United Nations Office on Drugs and Crime.* HIV and AIDS in Places of Detention. A toolkit for policymakers, programme managers, prison officers, and health care providers in prison settings. Vienna, Austria.

Other Media Communications

Gender differences in the treatment outcomes of HIV-infected jail detainees. Outbreak News this Week, WTAN 1340 Clearwater. Interviewed by Robert Herriman [radio] Tampa, Florida, February 8, 2014.

Caring for Justice-Involved Women. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014.

"Safe" Sex with IUDs Is Not Safe Enough. Ms. Magazine Online. Posted December 8, 2014. http://msmagazine.com/blog/2014/12/08/safe-sex-with-iuds-is-not-safe-enough/

Women's Health Behind Bars- Not so Black and Orange. Huffington Post. Posted December 18, 2014. http://www.huffingtonpost.com/jaimie-meyer/womens-health-behind-bars-not-so-black-and-orange_b_6308892.html

Opioid use in women is not just 'a fetus problem'. Boston Globe. Posted February 19, 2015. http://www.bostonglobe.com/opinion/2015/02/19/opioid-use-women-not-just-fetus-problem/8tTFfEtn4mOJ1K75rxEXPI/story.html

Distinct Challenges Affect Women's HIV Treatment Outcomes After Jail. NIDA Notes. Posted May 12, 2015. http://www.drugabuse.gov/news-events/nida-notes/2015/05/distinct-challenges-affect-womens-hiv-treatment-outcomes-after-jail

Caring for the dying, behind bars. Boston Globe. Posted online May 21, 2015; in print May 24, 2015. http://www.bostonglobe.com/opinion/2015/05/21/caring-for-dying-inmates/WNispkkTY8MoI6zYP8tSRO/story.html

Video abstract. AJPH Talks. Posted online July 28, 2015. http://ajphtalks.blogspot.com/

Invited Conference Presentations & Published Abstracts

Adherence to HIV treatment and care among previously homeless jail detainees. IAPAC HIV Treatment and Adherence Conference. Miami, Florida. May 2011.

Emergency Department Use by Released Prisoners with HIV. Connecticut Infectious Disease Society Annual Symposium. Orange, Connecticut. May 2011.

Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees. 5th Academic and Health Policy Conference on Correctional Health. Atlanta, Georgia. March 2012.

Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.

Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. Conference on Retroviruses and Opportunistic Infections (CROI). Atlanta, Georgia. March 2013.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. Connecticut Infectious Disease Society Annual Meeting. Orange, Connecticut. May 2013.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. HIV Intervention and Implementation Science Meeting. Bethesda, Maryland. September 2013.

Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration. Conference on Retroviruses and Opportunistic Infections (CROI). Boston, Massachusetts. March 2014.

Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration. Connecticut Infectious Disease Society Annual Meeting. Orange, Connecticut. May 2014.

Gender Differences in HIV and Criminal Justice Outcomes. College on Problems in Drug Dependence (CPDD). San Juan, Puerto Rico. June 2014.

Gender Differences in HIV and Criminal Justice Outcomes. International Women's and Children's Health and Gender Working Group. San Juan, Puerto Rico. June 2014.

Violence, Substance Use, and Sexual Risk among College Women. International Women's and Children's Health and Gender Working Group. Phoenix, Arizona. June 2015.

Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum. International Harm Reduction Conference. Kuala Lumpur, Malaysia. October 2015.

Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation). CDC National HIV Prevention Conference. Atlanta, Georgia. December 2015.

An Event-level Examination of Successful Condom Negotiation Strategies among College Women. International Women's and Children's Health and Gender Working Group. Palm Springs, California. June 2016.

Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation). 2017 Annual Meeting of the Society for Applied Anthropology. Santa Fe, New Mexico. April 2017.

A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine. International Women's and Children's Health and Gender Working Group. Montreal, Canada. June 2017.

Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women. International Women's and Children's Health and Gender Working Group. Montreal, Canada. June 2017.

A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine. NIDA International Forum. Montreal, Canada. June 2017.

Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons. International AIDS Society (IAS) Meeting. Paris, France. July 2017.

Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation). IDWeek: Annual Meeting of Infectious Diseases Society of America. San Diego, CA. October 2017.

The New Haven syringe services program. 2017 Connecticut Public Health Association Annual Conference. Plantsville, CT. October 2017.

Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut. 11th Academic and Health Policy on Conference on Correctional Health. Houston, TX. March 2018.

From prison's gate to death's door: Survival analysis of released prisoners with HIV. 2018 Conference on Retroviruses and Opportunistic Infections (CROI). Boston, MA. March 2018.

HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine. NIDA International. San Diego, CA. June 2018.

Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program. 22nd International AIDS Conference. Amsterdam, Netherlands. 23-27 July 2018.

HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study. 22nd International AIDS Conference. Amsterdam, Netherlands. 23-27 July 2018.

Service needs and access to care among participants in the New Haven Syringe Services Program (SA-15). 12th National Harm Reduction Conference. New Orleans, LA. October 2018.

Oral presentation: New Haven Syringe Service Program: A model of integrated harm reduction and health care services. American Public Health Association (APHA) Annual Meeting. San Diego, California. November 2018.

PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut. 12th Academic and Health Policy on Conference on Correctional Health. Las Vegas, Nevada. March 2019.

Released to Die: Elevated Mortality in People with HIV after Incarceration. 2019 Conference on Retroviruses and Opportunistic Infections (CROI). Seattle, Washington. March 2019.

Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women." Behaviors across Diverse Populations: Innovations in Science and Practice, APA Collaborative Perspectives on Addiction Annual Meeting. Providence, Rhode Island. April 2019.

Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan. 11th International Women's and Children's Health and Gender (InWomen's) Group. San Antonio, Texas. June 2019.

Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction. 2019 NIDA International Forum. San Antonio, Texas. June 2019.

Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? 14th International Conference on HIV Treatment and Prevention Adherence. Miami, Florida. June 2019.

Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications. CPDD 81st Annual Scientific Meeting. San Antonio, Texas. June 2019.

How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons. Harm Reduction International. Porto, Portugal. May 2019.

Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus. Society for Academic Emergency Medicine (SAEM) New England Regional Meeting (NERDS). Worcester, Massachusetts. March 2019.

Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks. 37th Annual Connecticut Infectious Disease Society Conference. New Haven, Connecticut. May 2019.

Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? American College of Physicians (ACP) Connecticut Chapter Scientific Meeting. Hartford, Connecticut. October 2019.

Oral presentation: Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? SGIM New England Regional Meeting. Boston, Massachusetts. November 2019.

Workshop presentation: Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration. Association for Justice-Involved Female Organizations Conference 2019. Atlanta, Georgia. December 2019.

Oral presentation: Can an interactive aid modify decisional preference for HIV pre-exposure prophylaxis (PrEP) among women seeking domestic violence services? description of a novel collaborative program and preliminary findings. National Conference on Health and Domestic Violence (NCHDV). Chicago, Illinois. March 2020.

Oral presentation: A Novel PrEP Demonstration Project for Justice-Involved Women and Members of their Risk Networks. 13th Academic and Health Policy Conference on Correctional Health. Raleigh, North Carolina. April 2020.

Impact of Motherhood Identity on Women's Substance Use and Engagement in Treatment Across the Lifespan. International Women's and Children's Health and Gender (InWomen's) Group. Hollywood, Florida. June 2020.

Invited Lectures/Seminars

Yale School of Medicine Affiliated

"HIV 101": Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. March 2011.

"Clostridium Difficile": Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. April 2013.

"Community-Acquired Infections." Student Microbiology Workshop, Yale University School of Medicine. September 2013.

"Hospital Associated Infections." Student Microbiology Workshop, Yale University School of Medicine. September 2014.

"Microbiology of the Central Nervous System." Student Microbiology Seminar. Yale University School of Medicine, Physician Associate Program. October 2014.

"Fever of Unknown Origin": Yale Affiliated Hospital Program, Greenwich Hospital Grand Rounds. January 2015.

"HIV and Women": Yale Affiliated Hospital Program, Greenwich Hospital Grand Rounds. May 2015.

"Clinical Care of HIV+ Women." Nathan Smith Clinic Lecture Series. May 2015.

"Implicit Bias and incarceration." Yale School of Medicine Pre-clinical clerkship seminar. September 2015.

Incarceration and Health Disparities." US Health and Justice course, Yale School of Medicine, Physician Assistant Program, and Yale School of Nursing. November 2015.

"Fever of Unknown Origin": Yale Affiliated Hospital Program, Danbury Hospital Teaching Rounds. January 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Greenwich Hospital Teaching Rounds. February 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. June 2016.

"Clostridium Difficile Infection." Yale Affiliated Hospital Program, Norwalk Hospital Resident Conference. October 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. November 2016.

"Mass Incarceration: Film and Panel Discussion." Yale Department of Psychiatry, Psychiatry and Film Series. December 2016.

"HIV 101." Yale Affiliated Hospital Program, Bridgeport Hospital Noon Conference. May 2017.

"HIV in the Criminal Justice System." Yale Affiliated Hospital Program, Danbury Hospital Noon Conference. June 2017.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2017.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Noon Conference. March 2018.

"HIV prevention for justice-involved women." Addiction Medicine Grand Rounds. May 2018.

"Diagnosis and Management of Urinary Tract Infections." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. November 2018.

"Bacteremia." Yale Medicine Residency Program Resident Noon Conference. March 2019.

"Clostridium Difficile." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2019.

Invited small group facilitator. "Taking a Substance Use History." Session delivered as a required component of the Interprofessional Longitudinal Clinical Experience (ILCE) course delivered to all first-year Yale medical, nursing and PA students. Yale School of Nursing. November 1, 2019.

Non-Yale School of Medicine Affiliated

"HIV and Addiction": Rhode Island Chapter of the Association of Nurses in AIDS Care, 7th Annual Education Day. September 2010.

"Incarceration as Opportunity: Prisoner Health and Health Interventions": Yale College Class of 1960 Criminal Justice Symposium. May 2013.

"Trends and obstacles associated with healthcare for incarcerated or recently incarcerated women." Arthur Liman Public Interest Program, Yale Law School. October 2015.

"Incarceration as Opportunity: Prisoner Health and Health Interventions." New England AIDS Education Training Center, Dartmouth Geisel School of Medicine. April 2016.

"Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches." Connecticut Advanced Practice Registered Nurse Society Annual Meeting. April 2016.

"Topics in Infectious Diseases." Evolutionary Medicine course, Frank H. Netter School of Medicine, Quinnipiac University. October 2016.

"Optimizing the HIV Care Continuum for People Who Use Drugs: Strategies to Address Health Disparities." Clinical Directors Network Webinar. January 2017.

"HIV prevention for justice-involved women." Frank H. Netter School of Medicine Faculty Seminar Series. March 2018.

Plenary: "Intersection of the HIV and Opioid Epidemics." CCO Annual HIV and Hepatitis Symposium: Regional Workshops and Annual Update 2018. Washington, DC. April 2018.

"HIV prevention and treatment for women involved in criminal justice systems." CT HIV/AIDS Identification and Referral task force (CHAIR), Center for Interdisciplinary Research on AIDS (CIRA). Yale School of Public Health. May 2018.

Discussant: "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda." Workshop on Women in Addictions Ten Years On, College of Problems on Drug Dependence. San Diego, CA. June 2018.

"PrEP Awareness among Special Populations of Women and People who Use Drugs." Clinical Directors Network Webinar. October 2018.

Panelist and Expert Witness: "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System." US Commission on Civil Rights, Briefing on Women in Prison: Seeking Justice Behind Bars. Washington, DC. February 2019.

Faculty: "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations" (Live Webcast). CME Outfitters. September 2019.

"PrEP in Special Populations: PrEP in People who Inject Drugs." New England AIDS Education Training Center Annual Primary Care Conference. Hartford, CT. March 2020.

EXHIBIT 10

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

AARON HOPE, *et al.*, Petitioners-Plaintiffs,	:	1:20-cv-562
v.	:	Hon. John E. Jones III
CLAIR DOLL, *in his official capacity as Warden of York County Prison, et al.*, Respondents-Defendants.	:	

MEMORANDUM AND ORDER

April 7, 2020

Pending before the Court is the Motion for Temporary Restraining Order and/or Preliminary Injunction filed by Petitioners-Plaintiffs Aaron Hope, Iwan Rahardja, Jesus De La Pena, Rakibu Adam, Duc Viet Lam, Yelena Mukhina, Nashom Gebretinsae, Ismail Muhammed, Glenn Weithers, Konstantin Bugarenko, Brisio Balderas-Dominguez, Viviana Ceballos, Wilders Paul, Marcos Javier Ortiz Matos, Alexander Alvarenga, Armando Avecilla, Coswin Ricardo Murray, Edwin Luis Crisostomo Rodriguez, Eldon Bernard Briette, Dembo Sannoh, Jesus Angel Juarez Pantoja and Alger Fracois, (collectively "Petitioners"). (Doc. 5).

For the reasons that follow, the temporary restraining order shall be granted and the Respondents shall be directed to immediately release Petitioners today on their own recognizance.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

Petitioners are a diverse group of individuals from around the world who are being held in civil detention by Immigration and Customs Enforcement, ("ICE"), at York County Prison and Pike County Correctional facility, ("the Facilities"), while they await final disposition of their immigration cases.

Each Petitioner suffers from chronic medical conditions and faces an imminent risk of death or serious injury if exposed to COVID-19. Hope is 32 years old and has serious respiratory problems that have led to his hospitalization for pneumonia. He also has sleep apnea and high blood pressure. (Doc. 1, ¶ 3). Rahardja is 51 years old and suffers from diabetes and hypertension. (Doc. 1, ¶ 4). De La Pena is 37 years old and suffers from severe asthma and hypertension and is over-weight. (Doc. 1, ¶ 5). Adam, 34 years old, suffers from asthma and high blood pressure. (Doc. 1, ¶ 6). Viet Lam is 50 years old and suffers from diabetes and high blood pressure. *Id.* at ¶ 7. Mukhina is 35 years old and suffers from asthma, a heart murmur, and hepatitis C, and has a history of blood clots and seizures. (Doc.1, ¶ 8). Gebretnisae is 28 years old and suffers from Cn's arthritis and nerve pain, requiring many medications. (Doc. 1, ¶ 9).

Muhammed is 69 years old and suffers from asthma, is pre-diabetic, and has recently lost a significant amount of weight. (Doc. 1, ¶ 10). Weithers is 59 years old and suffers from emphysema and chronic obstructive pulmonary

disease. (Doc. 1, ¶ 11). Bugarenko, age 49, suffers from pre-diabetes, high blood pressure, and diverticulitis, as well as debilitating pain that inhibits his ability to walk. (Doc. 1,¶ 12). Baldarez-Domingez is 47 years old and suffers from diabetes, atrial fibrillation, and high blood pressure. (Doc. 1, ¶ 13). Ceballos, 56 years old, suffers from high blood pressure. (Doc. 1, ¶ 14). Paul is 32 years old and suffers from traumatic brain injury, seizures, and headaches. (Doc. 1, ¶ 15).

Matos is 32 years old and suffers from diabetes. (Doc. 1, ¶ 16). Alvargena, age 46, suffers from diabetes, high blood pressure, atrial fibrillation, high cholesterol, and partial physical disability from a prior accident. (Doc. 1, ¶ 17). Avecilla is 53 years old and suffers from diabetes. (Doc 1, ¶ 18). Murray is 45 years old and suffers from asthma but has been unable to obtain an inhaler. (Doc. 1, ¶ 19). Rodriguez is 31 years old and suffers from asthma. (Doc. 1, ¶ 20). Briette is 46 years old and suffers from diabetes, high blood pressure, high cholesterol, depression, and anxiety. (Doc. 1, ¶ 21). Sannoh, 41 years old, suffers from diabetes requiring daily medication. (Doc. 1, ¶ 22). Pantoja is 36 years old and suffers from asthma, sleep apnea, and high blood pressure. (Doc.

1, ¶ 23). Francois is 45 years old and suffers from hypertension, pain when he urinates, and swollen feet. (Doc. 1, ¶ 24). [1]

Named as Respondents are: Clair Doll, Warden of York County Prison; Craig A. Lowe, Warden of Pike County Correctional Facility; Simona Flores-Lund, Field Office Director, ICE Enforcement and Removal Operations; Matthew Albence, Acting Director of ICE; and Chad Wolf, Acting Secretary of the Department of Homeland Security.

II. DISCUSSION

We had occasion to consider the substantially same set of circumstances less than a week ago in our opinion *Thakker v. Doll*. No. 1:20-CV00480 (M.D. Pa. Mar. 31, 2020) (Jones, J.) (discussing in-depth the potential severity of COVID-19, its prevalence across the globe, and its impact upon ICE detention facilities in particular). We now begin our analysis of Petitioners' claims guided by our previous findings.

i. Legal Standard

Courts apply one standard when considering whether to issue interim injunctive relief, regardless of whether a petitioner requests a temporary restraining order ("TRO") or preliminary injunction. *See Ellakkany v. Common Pleas Court of*

[1] We have previously held that ICE detainees have the requisite standing to bring claims based upon imminent contraction of COVID-19, and that a *habeas* petition is the proper vehicle to do so. *Thakker v. Doll*, No. 1:20-CV00480, at 5-6 (M.D. Pa. Mar. 31, 2020).

Montgomery Cnty., 658 Fed.Appx. 25, 27 (3d Cir. July 27, 2016) (applying one standard to a motion for both a TRO and preliminary injunction). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Apple Inc. v. Samsung Electronics Co.*, 695 F.3d 1370, 1373–74 (Fed. Cir. 2012) (quoting *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20, 129 S. Ct. 365 (2008)).

The Supreme Court has emphasized that "a preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997); *Apotex Inc. v. U.S. Food and Drug Admin.*, 508 F.Supp.2d 78, 82 (D.D.C. 2007) ("Because interim injunctive relief is an extraordinary form of judicial relief, courts should grant such relief sparingly."). "Awarding preliminary relief, therefore, is only appropriate 'upon a clear showing that the plaintiff is entitled to such relief.'" *Groupe SEC USA, Inc. v. Euro–Pro Operating LLC*, 774 F.3d 192, 197 (3d Cir. 2014) (quoting *Winter*, 555 U.S. at 22).

ii. Irreparable Harm

COVID-19 is a novel coronavirus that causes "serious, potentially permanent, damage to lung tissue, and can require extensive use of a ventilator. [20-cv-562, Doc. 3, Ex. 2]. The virus can also place greater strain on the heart muscle and can cause damage to the immune system and kidneys. (*Id.*)." *Thakker* at 10.

Because of these potentially catastrophic complications, COVID-19 has radically transformed our everyday lives in ways previously inconceivable. Most of the county can no longer leave their homes unless absolutely necessary.[2] "Large portions of our economy have come to a standstill. Children have been forced to attend school remotely. Workers deemed 'non-essential' to our national infrastructure have been told to stay home." *Thakker*. at 4. Indeed, the World Health Organization ("WHO") has declared a global pandemic[3] in light of the

[2] Sarah Mervosh, Denise Lu, and Vanessa Swales, "See Which States and Cities have Told Residents to Stay at Home," NEW YORK TIMES, https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html (last accessed April 7, 2020).

[3] The World Health Organization ("WHO") officially declared COVID-19 as global pandemic on March 11, 2020. *See WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020*, WORLD HEALTH ORGANIZATION, (March 11, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

stark realities we now face: over one million people worldwide have contracted COVID-19. Well over sixty thousand have perished as a result.[4]

Less than one week ago, we found that the threat of a COVID-19 outbreak in the Facilities constituted irreparable harm to substantially similar Petitioners, despite the fact that there were, at that time, *no* confirmed cases of COVID-19 in the Facilities. *Thakker*, at 7-19.[5] In so doing, we noted that "it is not a matter of *if* COVID-19 will enter Pennsylvania prisons, but *when* it is finally detected therein." *Id*. at 8 (emphasis in original).

We have, unfortunately, been proven correct in this regard. As of the time of this writing, the Pike County Correctional Facility has officially reported that four ICE detainees housed therein have tested positive for COVID-19.[6] Four Pike County Correctional employees have also tested positive. (Doc. 6, Ex. 3). An additional detainee at York County Prison has also tested positive. *See ICE Latest Statement*. And we can only assume that these numbers may well be much higher

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[4] *See Coronavirus Disease (COVID-19) Pandemic*, WORLD HEALTH ORGANIZATION, https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last accessed April 7, 2020).

[5] In *Thakker*, we considered the potential harm faced by ICE detainees in county prisons located in York, Pike, and Clinton Counties, finding that there was a high likelihood that Petitioners would face severe complications, and even death, should they contract COVID-19 in the Facilities—which we found to be a likely outcome of their continued detention. *Thakker* 7-19. Here, we again consider the likelihood of irreparable harm in two of those same facilities: those in York and Pike Counties.

[6] *ICE Latest Statement*, ICE GUIDANCE ON COVID-19, https://www.ice.gov/coronavirus#wcm-survey-target-id (last accessed April 7, 2020).

than reported—we have allegations before us that requests by detainees for COVID-19 tests have not been granted, despite explicit knowledge that the virus has entered the Facilities. (Doc. 6, Ex. 7).

We also have further declarations that no effective containment measures have been put into place to protect Petitioners.[7] Officers and medical staff, who regularly leave the confines of the Facilities and have ample opportunities to contract the virus elsewhere, do not reliably wear gloves and masks when interacting with inmates. (Doc. 3, Ex. 17; Doc. 3, Ex. 16, Doc. 3, Ex. 4; Doc. 3, Ex. 8; Doc. 3. Ex. 23). Temperature checks are infrequently conducted, even among detainees who had close contact with others who have since tested positive. (Doc. 3, Ex. 23). The cell blocks which housed those who test positive are not thoroughly evacuated and cleaned to prevent the spread. (Doc. 3, Ex. 4). We even have reports that detainees exhibiting COVID-like symptoms are remaining in general housing for days, and that once they are quarantined, no testing is being provided to those who remain. (Doc. 3, Ex. 8).

We have previously discussed in great detail how the incursion of COVID-19 into ICE detention facilities could result in catastrophic outcomes, particularly in light of the grim conditions present in these specific Facilities. *See* Thakker at

[7] We have previously discussed the overcrowding and unsanitary conditions present at these Facilities. *See Thakker* at 14-15.

14-15. It now seems that our worst fears have been realized—COVID-19 is spreading, and not nearly enough is being done to combat it. We cannot allow the Petitioners before us, all at heightened risk for severe complications from COVID-19, to bear the consequences of ICE's inaction. We therefore find that irreparable harm faces the Petitioners before us should they contract COVID-19.[8]

iii. Likelihood of Success on the Merits

Petitioners argue that they are "likely to establish a due process violation through conditions of confinement that expose them to the serious risks associated with COVID-19." (Doc. 6 at 13). For the reasons that follow, we agree.

As we previously stated in *Thakker*, Petitioners must show that their conditions of confinement "amount to punishment of the detainee." *Bell v. Wolfish*, 441 U.S. 520, 535 (1979). "To determine whether challenged conditions of confinement amount to punishment, this Court determines whether a condition of confinement is reasonably related to a legitimate governmental objective; if it is not, we may infer 'that the purpose of the governmental action is punishment that may not be constitutionally inflicted upon detainees *qua* detainees.'" *E. D. v. Sharkey*, 928 F.3d 299, 307 (3d Cir. 2019) (quoting *Hubbard v. Taylor*, 538 F.3d

[8] Many of our sister courts across the nation have agreed with our conclusion. *See Thakker* at 16-19.

229, 232 (3d Cir. 2008)). We therefore ask whether the conditions imposed are rationally related to a legitimate government purpose. They are not.

We previously held, considering the present living conditions present at the *same detention Facilities* now at issue here, that, "we can see no rational relationship between a legitimate government objective and keeping Petitioners detained in unsanitary, tightly-packed environments—doing so would constitute a punishment to Petitioners." *Thakker* at 20-21. There is no indication that there has been an improvement in conditions at the Facilities. Indeed, all indications point towards the contrary. There are now individuals who have tested positive at both Facilities,[9] and we have further accusations that those situations are not being properly contained.[10] "Considering, therefore, the grave consequences that will result from an outbreak of COVID-19, particularly to the high-risk Petitioners in this case, we cannot countenance physical detention in such tightly-confined, unhygienic spaces." *Thakker* at 21.

We further note that Respondents previously proffered legitimate government objective holds no greater sway here than it did in *Thakker*. The Respondents had

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[9] *ICE Latest Statement*, ICE GUIDANCE ON COVID-19, https://www.ice.gov/coronavirus#wcm-survey-target-id (last accessed April 7, 2020).

[10] *See* Doc. 3, Ex. 17; Doc. 3, Ex. 16, Doc. 3, Ex. 4; Doc. 3, Ex. 8; Doc. 3. Ex. 23 (alleging that proper medical protective equipment is not being used by Facility staff, that temperature checks and COVID-19 testing are not being performed on detainees in close contact with the virus, and that proper cleaning of housing blocks is not taking place).

maintained that "preventing detained aliens from absconding and ensuring that they appear for removal proceedings is a legitimate governmental objective." (*Thakker,* 20-cv-480, Doc. 35 at 38). However, "we note that ICE has a plethora of means *other than* physical detention at their disposal by which they may monitor civil detainees and ensure that they are present at removal proceedings, including remote monitoring and routine check-ins. Physical detention itself will place a burden on community healthcare systems and will needlessly endanger Petitioners, prison employees, and the greater community. We cannot see the rational basis of such a risk." *Thakker* at 21-22. We therefore find that Petitioners are likely to succeed on the merits of their due process "conditions of confinement" claim. [11]

[11] As previously discussed in *Thakker*, we also think it likely Petitioners will prevail under the more exacting Eighth Amendment standards as well. To succeed on an Eighth Amendment conditions of confinement claim, the Petitioners must show: (1) the deprivation alleged must objectively be "sufficiently serious," and (2) the "prison official must have a sufficiently culpable state of mind," such as deliberate indifference to the prisoner's health or safety. See Thomas v. Tice, 948 F.3d 133, 138 (3d Cir. 2020) (quoting Farmer v. Brennan, 511 U.S. 825, 834 (1994)). "COVID-19 has been shown to spread in the matter of a single day and would well prove deadly for Petitioners. Such a risk is objectively 'sufficiently serious.'" *Thakker* at n.15. Furthermore, we note that authorities can be "deliberately indifferent to an inmate's current health problems" when they "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year," including "exposure of inmates to a serious, communicable disease," even when "the complaining inmate shows no serious current symptoms." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). There is no requirement that Petitioners show that "they actually suffered from serious injuries" to succeed on this claim. *See Helling*, 509 U.S. at 33. "The current measures undertaken by ICE, including 'cohorting' detainees, are patently ineffective in preventing the spread of COVID-19," as is now evidenced by multiple positive COVID-19 tests in both Facilities. *Thakker* at n.15.

iv. Balancing of the Equities and Public Interest

The equities at issue and public interest "weigh heavily in Petitioners' favor." *Thakker* at 23. We have already noted that Petitioners face a very real risk of serious COVID-19 complications. We also find that Respondents face very little potential harm from Petitioner's immediate release. While we "agree that preventing Petitioners from absconding. . .is important, we note that Petitioners' failure to appear at future immigration proceedings would carry grave consequences of which Petitioners are surely aware. Further, it is our view that the risk of absconding is low, given the current restricted state of travel in the United States and the world during the COVID-19 pandemic." *Id.*

Finally, the public interest strongly encourages Petitioners' release. "As mentioned, Petitioners are being detained for civil violations of this country's immigration laws. Given the highly unusual and unique circumstances posed by the COVID-19 pandemic and ensuing crisis, 'the continued detention of aging or ill civil detainees does not serve the public's interest.'" *Thakker* at 23 (*citing Basank*, 2020 WL 1481503, *6; *see also Fraihat v. U.S. Imm. and Customs Enforcement*, 5:19 Civ. 1546, ECF No. 81-11 (C.D. Cal. Mar. 24, 2020) (opining that "the design and operation of detention settings promotes the spread of communicable diseases such as COVID-19"); *Castillo v. Barr*, CV-20-00605-TJH (C.D. Cal. 2020)). Releasing these high-risk Petitioners, and therefore providing more space for effective social

distancing within the Facilities, will clearly benefit the surrounding areas. Rural hospitals will be less overwhelmed by potential detainee COVID-19 cases and there will be less of a risk that Facilities staff will carry the virus into their homes and communities. "Efforts to stop the spread of COVID-19 and promote public health are clearly in the public's best interest, and the release of these fragile Petitioners from confinement is one step further in a positive direction." *Thakker* at 23-24.

III. CONCLUSION

"In times such as these, we must acknowledge that the *status quo* of a mere few weeks ago no longer applies. Our world has been altered with lightning speed, and the results are both unprecedented and ghastly. We now face a global pandemic in which the actions of each individual can have a drastic impact on an entire community. The choices we now make must reflect this new reality." *Thakker* at 24.

We have before us clear evidence that the protective measures in place in the York and Pike County prisons are not working. We can only expect the number of positive COVID-19 cases to increase in the coming days and weeks, and we cannot leave the most fragile among us to face that growing danger unprotected.

We are mindful that judicial decisions such as these are both controversial and difficult for the public to absorb. It is all too easy for some to embrace the notion that individuals such as Petitioners should be denied relief simply because they lack citizenship in this country. However, Article III Courts do not operate according to

polls or the popular will, but rather to do justice and to rule according to the facts and the law.

Based on the foregoing, we shall grant the requested temporary restraining order. Respondents, and the York County Prison and Pike County Correctional Facility shall be ordered to immediately release the Petitioners **today** on their own recognizance without fail.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. The Petitioners' Motion for Temporary Restraining Order, (Doc. 5), is **GRANTED**.
2. Respondents, and the York County Prison and Pike County Correctional Facility **SHALL IMMEDIATELY RELEASE** the Petitioners **TODAY** on their own recognizance.
3. Petitioners will **SELF-QUARANTINE** in their respective homes for **FOURTEEN (14) DAYS** from the date of release.
4. This TRO will expire on April 20, 2020 at 5:00 p.m.
5. No later than noon on April 13, 2020, the Respondents shall **SHOW CAUSE** why the TRO should not be converted into a preliminary injunction.
6. The Petitioners may file a response before the opening of business on April 16, 2020.

s/ John E. Jones III

John E. Jones III
United States District Judge

United States District Court
Central District of California
Western Division

FAOUR ABDALLAH FRAIHAT, Petitioner, v. CHAD T. WOLF, *et al.*, Respondents.	ED CV 20-00590 TJH (KSx) **Temporary Restraining Order and Order to Show Cause**

The Court has considered Petitioner Faour Abdallah Fraihat's application for a temporary restraining order, together with the moving and opposing papers.

Fraihat, now 58-years-old, suffers from multiple medical ailments, including asthma, for which he requires two different prescription inhalers. Fraihat is, currently, being detained at the Adelanto Detention Center ["Adelanto"], in San Bernardino County. San Bernardino County is within the Central District of California.

Fraihat filed this case as a petition for a writ of *habeas corpus*. Fraihat is a civil detainee, having been arrested by officers from the United States Department of Homeland Security's ["DHS"] Bureau of Immigration and Customs Enforcement

["BICE"] on December 19, 2016.

Adelanto is a private, for-profit immigration detention facility operated by Geo Group, Inc. Adelanto has the capacity to hold, under normal situations, well over 1,000 detainees through a contract with BICE. Over the years, and as recently as 2018, DHS's Office of the Inspector General had, repeatedly, found that significant and various health and safety risks existed at Adelanto.

Fraihat, a citizen of Jordan, has a history of various criminal convictions and immigration proceedings. In 1989, he was convicted of simple battery and sentenced to 20 days in jail. From 1994 to 1997, Fraihat served jail time for various unspecified convictions. In 2001, Fraihat was convicted for three crimes related to the manufacture and distribution of methamphetamine and served approximately 6 years in prison for those crimes ["2001 Conviction"]. In 2013, Fraihat was, again, convicted of a drug trafficking crime and sentenced to two years in prison, which he served.

On February 7, 2012, in response to a DHS motion, and based on the 2001 Conviction, an immigration judge reopened proceedings against Fraihat. On December 19, 2016, Fraihat was arrested by BICE officers and remains detained at Adelanto. Around June 27, 2017, Fraihat had a *Rodriguez* bond hearing, where bond was denied after a finding that he was a danger to the community. On October 30, 2017, an immigration judge ordered Fraihat removed to Jordan, based on the 2001 Conviction. Around December 22, 2017, Fraihat had a second *Rodriguez* bond hearing and, again, bond was denied after a finding that he was a danger to the community.

In 2019 – based on a change in California law and a stipulation of the parties – the San Bernardino Superior Court vacated the 2001 Conviction; Fraihat, then, pled guilty to two crimes related to the distribution of a controlled substance without reference to any particular controlled substance; and, then, the Superior Court sentenced Fraihat to time served for those two new charges.

Fraihat, then, moved the Board of Immigration Appeals ["BIA"] to reopen his removal order. That motion remains pending. Fraihat, also, moved the BIA for an

emergency stay of removal, which was denied. He, then, petitioned the Ninth Circuit for review of the BIA's denial of the stay of removal. The Ninth Circuit granted a temporary stay of removal, and set a briefing schedule. *See Fraihat v. Barr*, Ninth Circuit No. 20-70632 (Dkt. 5).

On March 17, 2020, Fraihat moved for a third bond hearing before an immigration judge based on the COVID-19 pandemic's "accelerating threat to his safety." As of the date of this order, Fraihat's motion for a bond hearing has not yet been resolved.

On August 19, 2019, Fraihat, and several other Adelanto detainees, filed a putative civil rights class action alleging, *inter alia*, that the conditions at Adelanto violated their constitutional rights. *See Faour Abdallah Fraihat, et al. v. United States Immigration and Customs Enforcement, et al.*, CV 19-1546 JGB. This order does not resolve or address the pending motion for a preliminary injunction in that class action.

On March 4, 2020, the State of California declared a state of emergency in response to the coronavirus and the resulting COVID-19 disease, which attacks the respiratory system, thereby making Fraihat particularly vulnerable given his history of asthma. On March 10, 2020, San Bernardino County followed suit and declared a state of emergency. On March 11, 2020, the World Health Organization ["WHO"] declared COVID-19 to be a global pandemic. On March 13, 2020, President Donald J. Trump formally acknowledged and declared a national emergency in response to WHO's pandemic declaration.

On March 18, 2020, BICE announced that "[t]o ensure the welfare and safety of the general public as well as officers and agents in light of the ongoing COVID-19 pandemic response, [it] will temporarily adjust its enforcement posture beginning today … [and that its] highest priorities are to promote life-saving and public safety activities." Further, BICE stated that it would focus enforcement "on public safety risks and individuals subject to mandatory detention based on criminal grounds [, and for those people who do not fall into those categories, agents] will exercise discretion to

delay enforcement actions until after the crisis or utilize alternatives to detention, as appropriate."

According to the United States Centers for Disease Control and Prevention, the coronavirus is spread mainly through person-to-person contact. More specifically, the coronavirus is spread between people who are in close contact – within about 6 feet – with one another through respiratory droplets produced when an infected person coughs or sneezes. The droplets can land in the mouths or noses, or can be inhaled into the lungs, of people who are within about 6 feet of the infected person. Moreover, studies have established that the coronavirus can survive up to three days on various surfaces.

COVID-19 is highly contagious and has a mortality rate ten times greater than influenza. Most troublesome is the fact that people infected with the coronavirus can be asymptomatic during the two to fourteen day COVID-19 incubation period. During that asymptomatic incubation period, infected people are, unknowingly, capable of spreading the coronavirus. Despite early reports, no age group is safe from COVID-19. While older people with pre-existing conditions are the most vulnerable to COVID-19-related mortality, young people without preexisting conditions have, also, succumbed to COVID-19. There is no specific treatment, vaccine or cure for COVID-19.

Because of the highly contagious nature of the coronavirus and the, relatively high, mortality rate of COVID-19, the disease can spread uncontrollably with devastating results in a crowded, closed facility, such as an immigration detention center.

The Court will take judicial notice of the following facts, as set forth in the temporary retraining order issued by this Court on March 27, 2020, in *Castillo v. Barr*, CV 20-00605 TJH. At Adelanto, a holding area can contain 60 to 70 detainees, with a large common area and dormitory-type sleeping rooms housing four or six detainees with shared sinks, toilets and showers. Guards regularly rotate through the various holding areas several times a day. At meal times – three times a day – the 60 to 70

detainees in each holding area line up together, sometimes only inches apart, in the cafeteria. The guards, detainees and cafeteria workers do not regularly wear gloves or masks to prevent the spread of the coronavirus. While detainees have access to gloves, there is no requirement that they wear them. Detainees do not have access to masks or hand sanitizer – though thorough hand washing could be more effective than hand sanitizers at preventing the spread of the coronavirus.

Just days ago, the first BICE detainee was confirmed to have been infected with COVID-19 in New Jersey at the Bergin County Jail, a BICE detention facility. Moreover, last week, a correctional officer at the Bergin County Jail was, also, confirmed to have been infected.

On March 26, 2020, Judge Analisa Torres of the United States District Court for the Southern District of New York issued an order releasing certain immigration detainees, stating the following:

> The nature of detention facilities makes exposure and spread of the virus particularly harmful. Jaimie Meyer M.D., M.S., who has worked extensively on infectious diseases treatment and prevention in the context of jails and prisons, recently submitted a declaration in this district noting that the risk of COVID-19 to people held in New York-area detention centers, including the Hudson, Bergen County, and Essex County jails, "is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected." Meyer Decl. ¶ 7, *Velesaca v. Wolf*, 20 Civ. 1803 (S.D.N.Y. Feb. 28, 2020), ECF No. 42.
>
> Moreover, medical doctors, including two medical experts for the Department of Homeland Security, have warned of a "tinderbox scenario" as COVID-19 spreads to immigration detention centers and the resulting "imminent risk to the health and safety of immigrant detainees" and the public. Catherine E. Shoichet, *Doctors Warn of "Tinderbox scenario" if*

> *Coronavirus Spreads in ICE Detention*, CNN (Mar. 20, 2020), https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html. "It will be nearly impossible to prevent widespread infections inside the Hudson, Bergen, and Essex County jails now that the virus is in the facilities because detainees live, sleep, and use the bathroom in close proximity with others, and because '[b]ehind bars, some of the most basic disease prevention measures are against the rules or simply impossible.'" Petition ¶ 47 (internal quotation marks and citation omitted).

Basank, et al., v. Decker, et al., 20 Civ. 2518 (S.D.N.Y., Feb. 28, 2020), ECF No. 11.

On March 23, 2020, the Ninth Circuit ordered, *sua sponte* and without further explanation, the release of an immigration detainee "[i]n light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers." *Xochihua-Jaimes v. Barr*, 2020 WL 1429877, No. 18-71460 (9th Cir. Mar. 23, 2020).

On March 23, 2020, Fraihat filed a petition for a writ of *habeas corpus*, pursuant to 28 U.S.C. § 2241. Fraihat based his petition on two claims: (1) In light of the recent COVID-19 pandemic, the conditions of his confinement are, now, unconstitutional; and (2) His continued detention without a bond hearing is unlawful. Fraihat, now, moves for a temporary restraining order for his immediate release from Adelanto.

Fraihat is entitled to a temporary restraining order if he shows: (1) A likelihood of success on the merits; (2) That he is likely to suffer irreparable harm in the absence of relief; (3) The balance of equities tip in his favor; and (4) An injunction is in the public's interest. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Under the Ninth Circuit's sliding scale approach, a stronger showing of one element may offset a weaker showing of another. *See Pimentel v. Dreyfus*, 670 F.3d 1096, 1105 (9th Cir. 2012). Accordingly, Fraihat is entitled to a temporary restraining order

if "serious questions going to the merits [are] raised and the balance of hardships tips sharply in [his] favor." *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011).

When the Government detains a person for the violation of an immigration law, the person is a civil detainee, even if he has a prior criminal conviction. *See Zadvydas v. Davis*, 533 U.S. 678, 690 (2001). As a civil detainee, Fraihat is entitled to more considerate treatment than criminal detainees, whose conditions of confinement are designed to punish. *See Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982). Moreover, under the Fifth Amendment's Due Process Clause, a civil detainee cannot be subjected to conditions that amount to punishment. *See King v. Cty. of L.A.*, 885 F.3d 548, 556-557 (9th Cir. 2018).

When the Government takes a person into custody and detains him against his will, the Constitution imposes upon the Government a duty to assume responsibility for that detainee's safety and general well being. *See Helling v. McKinney*, 509 U.S. 25, 32 (1993). Under the Eighth Amendment, the Government must provide criminal detainees with basic human needs, including reasonable safety. *Helling*, 509 U.S. at 32. The Government violates the Eighth Amendment if it confines a criminal detainee in unsafe conditions. *See Helling*, 509 U.S. at 33. Moreover, the Government may not "ignore a condition of confinement that is sure or very likely to cause serious illness." *See Helling*, 509 U.S. at 32.

A civil detainee's constitutional rights are violated if a condition of his confinement places him at substantial risk of suffering serious harm, such as the harm caused by a pandemic. *See Smith v, Wash.*, 781 F. App'x. 595, 588 (9th Cir. 2019). At a minimum, here, the Government owes a duty to Fraihat, as a civil immigration detainee, to reasonably abate known risks. *See Castro v. Cty. of Los Angeles*, 833 F.3d 1060, 1071 (9th Cir. 2016). Inadequate health and safety measures at a detention center cause cognizable harm to every detainee at that center. *See Parsons v. Ryan*, 754 F.3d 657, 679 (9th Cir. 2014).

Here, Fraihat argued that the conditions at Adelanto expose him to a substantial risk of suffering serious harm – increasing his exposure to or contracting COVID-19. When the Government detains a person, thereby taking custody of that person, it creates a special relationship wherein the Government assumes responsibility for that detainee's safety and well-being. *See, e.g., Henry A. v. Willden*, 678 F.3d 991, 998 (9th Cir. 2012). If the Government fails to provide for a detainee's basic human needs, including medical care and reasonable safety, the Due Process Clause is violated. *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989). Indeed, the Due Process Clause mandates that civil immigration detainees are entitled to more than minimal human necessities. *See Jones v. Blanas*, 393 F.3d 918, 931 (9th Cir. 2004). At a minimum, here, the Government owes a duty to Fraihat, as a civil immigration detainee, to reasonably abate known risks. *See Castro v. Cty. of Los Angeles*, 833 F.3d 1060, 1071 (9th Cir. 2016). Inadequate health and safety measures at a detention center cause cognizable harm to every detainee at that center. *See Parsons v. Ryan*, 754 F.3d 657, 679 (9th Cir. 2014).

Because Fraihat, here, has asserted a claim for violations of his Fifth Amendment substantive due process rights, and those claims exceed the jurisdictional limits of the Immigration Court and the Board of Immigration Appeals, he need not first exhaust his administrative remedies. *Garcia-Ramirez v. Gonzales*, 423 F.3d 935, 938 (9th Cir. 2005).

The Government argued that Fraihat lacks standing because he cannot establish that he would suffer a concrete, non-hypothetical injury absent a temporary restraining order in that his likelihood of contracting COVID-19 is speculative. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561 (1992).

However, it is clear that "[a] remedy for unsafe conditions need not await a tragic event." *Helling*, 509 U.S. at 33. The Government cannot be "deliberately indifferent to the exposure of [prisoners] to a serious, communicable disease on the ground that the complaining [prisoner] shows no serious current symptoms." *Helling*, 509 U.S. at 33.

"That the Eighth Amendment protects against future harm to inmates is not a novel proposition." *Helling*, 509 U.S. at 33. The Supreme Court clearly stated that "… the Eighth Amendment protects [prisoners] against sufficiently imminent dangers as well as current unnecessary and wanton infliction of pain and suffering…" *Helling*, 509 U.S. at 33. Indeed, the Court concluded that where prisoners in punitive isolation were crowded into cells and some of them had infectious maladies, "… the Eighth Amendment required a remedy, even though it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed." *Helling*, 509 U.S. at 33. Civil detainees are entitled to greater liberty protections than individuals detained under criminal processes. *See Jones*, 393 F.3d at 932.

In its *amicus* brief filed in *Helling*, the Government stated that it "… recognizes that there may be situations in which exposure to toxic or similar substances would present a risk of sufficient likelihood or magnitude – and in which there is a sufficiently broad consensus that exposure of *anyone* to the substance should therefore be prevented – that the [Eighth] [A]mendment's protection would be available even though the effects of exposure might not be manifested for some time." *Helling*, 509 U.S. at 34. The Government, here, cannot say, with any degree of certainty, that no one – staff or detainee – at Adelanto has not been, or will not be, infected with the coronavirus. The science is well established – infected, asymptomatic carriers of the coronavirus are highly contagious. Moreover, Fraihat, presently, is suffering from a condition of confinement that takes away, *inter alia*, his ability to socially distance. The Government cannot be deliberately indifferent to Fraihat's potential exposure to a serious, communicable disease on the ground that he is not, now, infected or showing current symptoms. *See Helling*, 509 U.S. at 32.

It is "cruel and unusual punishment to hold convicted criminals in unsafe conditions." *Helling*, 509 U.S. at 33. The Eighth Amendment is violated when a condition of a criminal detainee's confinement puts him at substantial risk of suffering

serious harm and that the condition causes suffering inconsistent with contemporary standards of human decency. *See Smith v. Wash.*, 781 F. App'x. 595, 597-598 (9th Cir. 2019). However, a civil detainee seeking to establish that the conditions of his confinement are unconstitutional need only show that his conditions of confinement "put [him] at substantial risk of suffering serious harm." *See Smith*, 781 F. App'x. 597-598. Here, BICE cannot be deliberately indifferent to the potential exposure of civil detainees to a serious, communicable disease on the ground that the complaining detainee shows no serious current symptoms, or ignore a condition of confinement that is more than very likely to cause a serious illness. *See Helling*, 509 U.S. at 32.

Under the Due Process Clause, a civil detainee cannot be subject to the current conditions of confinement at Adelanto. The Supreme Court has acknowledged that it has "… great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Helling*, 509 U.S. at 33

As the Court writes this order, the number of confirmed COVID-19 cases in the United States has already exceeded the number of confirmed cases in every other country on this planet. Indeed, all of the experts and political leaders agree that the number of confirmed cases in the United States will only increase in the days and weeks ahead. The number of cases in the United States has yet to peak. In San Bernardino County, the number of confirmed cases, there, has more than tripled over the past week.

The risk that Fraihat will flee, given the current global pandemic, is very low given, further, that he has matters pending before the BIA and the Ninth Circuit. The Court is cognizant of the immigration judges' findings that Fraihat is a danger to the community. However, the Court must acknowledge that, while he has committed prior criminal offenses in this country, Fraihat has completed the sentences imposed for those offenses. Notably, Fraihat is not a criminal detainee; he is civil detainee entitled to

more considerate treatment than criminal detainees. *See Youngberg*. Nevertheless, Fraihat should be aware that if he is ordered released and, then, violates any federal, state or local criminal law, it will have a dire impact on his pending appeals and all further proceedings in this case.

Civil detainees must be protected by the Government. Fraihat has not been protected. He is not kept at least 6 feet apart from others at all times. He has been put into a situation where he has been forced to touch surfaces touched by other detainees, such as with common sinks, toilets and showers. Moreover, the Government cannot deny the fact that the risk of infection in immigration detention facilities – and jails – is particularly high if an asymptomatic guard, or other employee, enters a facility. While social visits have been discontinued at Adelanto, the rotation of guards and other staff continues.

Accordingly, Fraihat has established that there is more than a mere likelihood of his success on the merits for his first claim, which is based on his Due Process rights. *See Winter*, 555 U.S. at 20. The Court did not reach, and did not consider, Fraihat's second claim – failure to be released on bond – as a basis for the relief being granted by this temporary restraining order.

Fraihat has established that he is likely to suffer irreparable harm in the absence of relief. *See Winter*, 555 U.S. at 20. It is well established that the deprivation of constitutional rights unquestionably constitutes irreparable injury. *See Hernanez v. Session*, 872 F.3d 976, 994 (9th Cir. 2017).

The balance of the equities tip sharply in his favor. Fraihat faces irreparable harm to his constitutional rights and health. Indeed, there is no harm to the Government when a court prevents the Government from engaging in unlawful practices. *See Rodriguez v. Robbins*, 715 F.3d 1127, 1145 (9th Cir. 2013).

Finally, the emergency injunctive relief sought, here, is absolutely in the public's best interest. The public has a critical interest in preventing the further spread of the coronavirus. An outbreak at Adelanto would, further, endanger all of us – Adelanto

detainees, Adelanto employees, residents of San Bernardino County, residents of the State of California, and our nation as a whole.

This is an unprecedented time in our nation's history, filled with uncertainty, fear, and anxiety. But in the time of a crisis, our response to those at particularly high risk must be with compassion and not apathy. The Government cannot act with a callous disregard for the safety of our fellow human beings.

Accordingly,

It is Ordered that the application for a temporary restraining order be, and hereby is, **Granted**.

It is further Ordered that Respondents shall, by 5:00 p.m. on March 31, 2020, release Petitioner Faour Abdallah Fraihat from custody pending further order of this Court, and subject to the following conditions of release:

1. Petitioner shall reside, and shelter in place, at the residence of Radi Saad, 909 South Acacia Road, Rialto, California 92376 ["the Residence"];
2. Petitioner shall be transported from the Adelanto Detention Center directly to the Residence by Radi Saad;
3. Petitioner shall not leave the Residence, pending further order of the Court, except to obtain medical care;
4. Petitioner shall not violate any federal, state or local laws; and
5. At the discretion of DHS and/or BICE, to enforce the above restrictions, Petitioner's whereabouts may be monitored by telephonic and/or electronic and/or GPS monitoring and/or a location verification system and/or an automated identification system. If necessary to comply with the permitted monitoring, Petitioner shall ensure the presence of a residential telephone line without devices and/or services which may interrupt operation of any

monitoring equipment.

It is further Ordered that Respondents shall show cause, if they have any, as to why the Court should not issue a preliminary injunction in this case. Respondents' response, if any, to this order to show cause shall be filed by Noon on April 6, 2020. Fraihat's reply, if any, to Respondents' response shall be filed by Noon on April 9, 2020. The matter will then stand submitted.

Date: March 30, 2020

Terry J. Hatter, Jr.
Senior United States District Judge

SUPREME COURT OF NEW JERSEY
DOCKET NO. 084230

CRIMINAL ACTION

In the Matter of the Request to Commute or Suspend County Jail Sentences

CONSENT ORDER

This matter having come before the Court on the request for relief by the Office of the Public Defender (see attached letter dated March 19, 2020), seeking the Court's consideration of a proposed Order to Show Cause (see attached) designed to commute or suspend county jail sentences currently being served by county jail inmates either as a condition of probation for an indictable offense or because of a municipal court conviction; and

The Court, on its own motion, having relaxed the Rules of Court to permit the filing of the request for relief directly with the Supreme Court, based on the dangers posed by Coronavirus disease 19 ("COVID-19"), and the statewide impact of the nature of the request in light of the Public Health Emergency and State of Emergency declared by the Governor. *See* Executive Order No. 103 (2020) (Mar. 9, 2020); and

The Office of the Attorney General, the County Prosecutors Association, the Office of the Public Defender, the American Civil Liberties Union of New Jersey having engaged in mediation before the Honorable Philip S. Carchman, P.J.A.D. (ret.); and

The parties having reviewed certifications from healthcare professionals regarding the profound risk posed to people in correctional facilities arising from the spread of COVID-19; and

The parties agreeing that the reduction of county jail populations, under appropriate conditions, is in the public interest to mitigate risks imposed by COVID-19; and

It being agreed to by all parties as evidenced by the attached duly executed consent form;

IT IS HEREBY ORDERED, that

A. No later than 6:00 a.m. on Tuesday, March 24, 2020, except as provided in paragraph C, any inmate currently serving a county jail sentence (1) as a condition of probation, or (2) as a result of a municipal court conviction, shall be ordered released. The Court's order of release shall include, at a minimum, the name of each inmate to be released, the inmate's State Bureau of Identification (SBI) number, and the county jail where the inmate is being detained, as well as any standard or

specific conditions of release. Jails shall process the release of inmates as efficiently as possible, understanding that neither immediate nor simultaneous release is feasible.

1. For inmates serving a county jail sentence as a condition of probation, the custodial portion of the sentence shall either be served at the conclusion of the probationary portion of the sentence or converted into a "time served" condition, at the discretion of the sentencing judge, after input from counsel.
2. For inmates serving a county jail sentence as a result of a municipal court conviction, the custodial portion of the sentence shall be suspended until further order of this Court upon the rescission of the Public Health Emergency declared Executive Order No. 103, or deemed satisfied, at the discretion of the sentencing judge, after input from counsel.

B. No later than noon on Thursday, March 26, 2020, except as provided in paragraph C, any inmate serving a county jail sentence for any reason other than those described in paragraph A shall be ordered released. These sentences include, but are not limited to (1) a resentencing following a finding of a violation of probation in any Superior Court or municipal court, and (2) a county jail sentence not tethered to a

probationary sentence for a fourth-degree crime, disorderly persons offense, or petty disorderly persons offense in Superior Court. The custodial portion of the sentence shall be suspended until further order of this Court upon the rescission of the Public Health Emergency declared Executive Order No. 103, or deemed satisfied, at the discretion of the sentencing judge, after input from counsel. Jails shall process the release of inmates as efficiently as possible, understanding that neither immediate nor simultaneous release is feasible.

C. Where the County Prosecutor or Attorney General objects to the release of an inmate described in Paragraph A, they shall file a written objection no later than 5:00 p.m. on Monday, March 23, 2020. Where the County Prosecutor or Attorney General objects to the release of an inmate described in Paragraph B, they shall file a written objection no later than 8:00 a.m. on Thursday, March 26, 2020.

1. The objection shall delay the order of release of the inmate and shall explain why the release of the inmate would pose a significant risk to the safety of the inmate or the public.
2. Written objections shall be filed by email to the Supreme Court Emergent Matter inbox with a copy to the Office of the Public Defender.

3. The Office of the Public Defender shall provide provisional representation to all inmates against whom an objection has been lodged under this Paragraph.
4. The Office of the Public Defender shall, no later than 5:00 p.m. on Tuesday, March 24, 2020, provide responses to any objections to release associated with inmates described in Paragraph A, as it deems appropriate. The Office of the Public Defender shall, no later than 5:00 p.m. on Thursday, March 26, 2020, provide responses to any objections to release associated with inmates described in Paragraph B, as it deems appropriate.
5. The Court shall appoint judge(s) or Special Master(s) to address the cases in which an objection to release has been raised.
    a. On or before Wednesday, March 25, 2020, the judge(s) or Special Master(s) will begin considering disputed cases arising from Paragraph A; on or before Friday, March 27, 2020, the judge(s) or Special Master(s) will consider disputed cases arising from Paragraph B.
        i. The judge(s) or Special Master(s) shall conduct summary proceedings, which shall be determined on the papers. In the event the judge(s) or Special

Master(s) conduct a hearing of any sort, inmates' presence shall be waived.

ii. Release shall be presumed, unless the presumption is overcome by a finding by a preponderance of the evidence that the release of the inmate would pose a significant risk to the safety of the inmate or the public.

iii. At any point, the Prosecutor may withdraw its objection by providing notice to the judge(s) or Special Master(s) with a copy to the Office of the Public Defender. In that case, inmates shall be released subjected to the provisions of Paragraphs D-I.

iv. If the judge(s) or Special Master(s) determine by a preponderance of the evidence that the risk to the safety of the inmate or the public can be effectively managed, the judge(s) or Special Master(s) shall order the inmate's immediate release, subject to the provisions of paragraphs D-I.

1. The Order of the judge(s) or Special Master(s) may be appealed on an emergent basis, in a summary manner to the Appellate Division.
2. Should a release Order be appealed, the release Order shall be stayed pending expedited review by the Appellate Division.
3. The record on appeal shall consist of the objection and response filed pursuant to this Paragraph.

v. If the judge(s) or Special Master(s) determine by a preponderance of the evidence that risks to the safety of the inmate or the public cannot be effectively managed, the judge(s) or Special Master(s) shall order the inmate to serve the balance of the original sentence.

1. The Order of the judge(s) or Special Master(s) may be appealed on an emergent basis, in a summary manner to the Appellate Division.

2. Should an Order requiring an inmate to serve the balance of his sentence be appealed, the Appellate Division shall conduct expedited review.
3. The record on appeal shall consist of the objection and response filed pursuant to this Paragraph.

b. The judge(s) or Special Master(s) should endeavor to address all objections no later than Friday, March 27, 2020.

D. Any warrants associated with an inmate subject to release under this order, other than those associated with first-degree or second-degree crimes, shall be suspended. Warrants suspended under this Order shall remain suspended until ten days after the rescission of the Public Health Emergency associated with COVID-19. *See* Executive Order No. 103 (2020) (Mar. 9, 2020).

E. In the following circumstances, the county jail shall not release an inmate subject to release pursuant to Paragraphs A, B, or C(5)(a)(iii) or (iv), absent additional instructions from the judge(s) or Special Master(s):

1. For any inmate who has tested positive for COVID-19 or has been identified by the county jail as presumptively positive for COVID-19, the county jail shall immediately notify the parties and the County Health Department of the inmate's medical condition, and shall not release the inmate without further instructions from the judge(s) or Special Master(s). In such cases, the parties shall immediately confer with the judge(s) or Special Master(s) to determine a plan for isolating the inmate and ensuring the inmate's medical treatment and/or mandatory self-quarantine.
2. For any inmate who notifies the county jail that he or she does not wish, based on safety, health, or housing concerns, to be released from detention pursuant to this Consent Order, the county jail shall immediately notify the parties of the inmate's wishes, and shall not release the inmate without further instructions from the judge(s) or Special Master(s). In such cases, the parties shall immediately confer with the judge(s) or Special Master(s) to determine whether to release the inmate over the inmate's objection.

F. Where an inmate is released pursuant to Paragraphs A, B, or C(5)(a)(iii) or (iv), conditions, other than in-person reporting, originally imposed by the trial court shall remain in full force and effect. County jails shall inform all inmates, prior to their release, of their continuing obligation to abide by conditions of probation designed to promote public safety. Specifically:

1. No-contact orders shall remain in force.
2. Driver's license suspensions remain in force.
3. Obligations to report to probation officers in-person shall be converted to telephone or video reporting until further order of this Court.
4. All inmates being released from county jails shall comply with any Federal, State, and local laws, directives, orders, rules, and regulations regarding conduct during the declared emergency. Among other obligations, inmates being released from county jails shall comply with Executive Order No. 107 (2020) (Mar. 21, 2020), which limits travel from people's homes and mandates "social distancing," as well as any additional Executive Orders issued by the Governor during the Public Health Emergency associated with COVID-19.

5. All inmates being released from county jails are encouraged to self-quarantine for a period of fourteen (14) days.

6. Unless otherwise ordered by the judge(s) or Special Master(s), any inmate being released from a county jail who appears to be symptomatic for COVID-19 is ordered to self-quarantine for a period of fourteen (14) days and follow all applicable New Jersey Department of Health protocols for testing, treatment, and quarantine or isolation.

G. County Prosecutors and other law enforcement agencies shall, to the extent practicable, provide notice to victims of the accelerated release of inmates.

1. In cases involving domestic violence, notification shall be made. N.J.S.A. 2C:25-26.1. Law enforcement shall contact the victim using the information provided on the "Victim Notification Form." Attorney General Law Enforcement Directive No. 2005-5.

a. Where the information provided on the "Victim Notification Form" does not allow for victim contact, the Prosecutor shall notify the Attorney General.

b. If the Attorney General, or his designee, is convinced that law enforcement has exhausted all reasonable efforts to contact the victim, he may relax the obligations under N.J.S.A. 2C:25-26.1.

2. In other cases with a known victim, law enforcement shall make all reasonable efforts to notify victims of the inmate's accelerated release.

3. To the extent permitted by law, the Attorney General agrees to relax limitations on benefits under the Violent Crimes Compensation Act (N.J.S.A. 52:4B-1, *et seq.*) to better provide victims who encounter the need for safety, health, financial, mental health or legal assistance from the State Victims of Crime Compensation Office.

H. The Office of the Public Defender agrees to provide the jails information to be distributed to each inmate prior to release that includes:

1. Information about the social distancing practices and stay-at-home guidelines set forth by Executive Order No. 107, as well as other sanitary and hygiene practices that limit the spread of COVID-19;

2. Information about the terms and conditions of release pursuant to this consent Order;

3. Guidance about how to contact the Office of the Public Defender with any questions about how to obtain services from social service organizations, including mental health and drug treatment services or any other questions pertinent to release under this consent Order.

I. Any inmate released pursuant to this Order shall receive a copy of this Order, as well as a copy of any other Order that orders their release from county jail, prior to their release.

J. Relief pursuant to this Order is limited to the temporary suspension of custodial jail sentences; any further relief requires an application to the sentencing court.

3/22/2020 9:50 p.m.	/s/Stuart Rabner
Date	Chief Justice Stuart Rabner, for the Court

The undersigned hereby consents to the form and entry of the foregoing Order.

3/22/2020	/s/Gurbir S. Grewal
Date	Office of the Attorney General
3/22/2020	/s/Angelo J. Onofri
Date	County Prosecutors Association of New Jersey
3/22/2020	/s/Joseph E. Krakora
Date	Office of the Public Defender
3/22/2020	/s/Alexander Shalom
Date	American Civil Liberties Union of New Jersey

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

LILIAN PAHOLA CALDERON JIMENEZ AND LUIS GORDILLO, ET AL., individually and on behalf of all others similarly situated,	)	
Petitioners-Plaintiffs,	)	
v.	)	C.A. No. 18-10225-MLW
CHAD WOLF, ET AL.,	)	
Respondents-Defendants.	)	

MEMORANDUM AND ORDER

WOLF, D.J. March 26, 2020

Attached is a transcript of the decision, issued orally on March 25, 2020, granting the Motion for Immediate Interim Release of Class Member Salvador Rodriguez-Aguasviva (Docket No. 500).

UNITED STATES DISTRICT JUDGE

* * * * *

THE COURT: I'm going to decide this matter, and I will explain my decision. The transcript will be a record of the decision and you must order it. It's possible I'll write this up, but I do think this is an urgent matter and I should tell you my decision, so I will.

First, I've concluded for the reasons described by the Second Circuit in Mapp v. Reno, 241 F. 3d 221 at 230, a 2001 Second Circuit case, that District Courts do have the power to order the release of immigration detainees on bail. I don't think that the REAL ID Act alters that fundamental authority.

As I said earlier, I believe that the Glynn v. Donnelly case, the First Circuit case, 470 F.2d 95, 98 is distinguishable in a material respect. In Glynn, the First Circuit did hold that in certain extraordinary circumstances a District Court could release a detained petitioner before the petition was decided on the merits. It created a higher standard or stated a higher standard than the Second Circuit in Mapp. In Glynn, the petitioner was somebody who had been convicted of a crime. I believe his appeal had been denied, and then he was petitioning for habeas corpus, but he had no presumption of innocence.

In this case, it's important to remember we're talking about a civil detainee, somebody who has never been charged, let alone convicted of any crime. And I think that the Mapp

test or something similar or perhaps less is appropriate. As I said, the Mapp test where the court in Mapp said -- I don't know -- somebody perhaps didn't mute their phone because, unless I'm hearing the court reporter, there's something clicking, banging.

But the court in Mapp said the court considering a habeas petitioner's fitness for bail must inquire into whether the habeas petitioner raises substantial claims and whether extraordinary circumstances exist to make the grant of bail necessary to make the habeas remedy effective. And I would add to that that, even if those requirements are met, the court would have to be satisfied that the petitioner would not be a danger to the community, reasonably assured that the petitioner would not be a danger to the community or not would flee if released on reasonable feasible conditions.

I do find, without expressing any prediction of how the merits will be resolved, that a substantial claim or question is raised by the petitioner's habeas petition. The initial description by ICE of the reason for his detention -- well, the reason for his detention sent to petitioner's counsel in an email was that in effect -- well, that he was likely to be unable -- the petitioner was likely to be unable to receive an approved I-601A because he did not appear at his removal hearing. He was ordered removed in absentia. The essence of this, the way it was stated initially indicated that ICE was

under the impression or misimpression that the petitioner is ineligible for an I-601A.

While I've commended Mr. Lyons and Mr. Charles on many things they've done, since June 2018, I have found ICE has repeatedly failed to understand its own regulations as I held in 2018. And I learned, to my dismay, in the fall of 2019, when the witness responsible for much of the national program for many years testified that he didn't understand -- he didn't realize there was a regulation that required that everybody detained more than six months had to be interviewed. It would be sadly consistent with the pattern in this case if ICE misunderstood whether somebody who failed to appear for a removal hearing was ineligible for an I-601A.

And indeed it appears that ICE's position has evolved and they don't take that position anymore. Mr. Lyons has articulated in his declaration other reasons for the detention, but there is the question of whether those reasons were in his mind when he decided to detain the petitioner or whether the affidavit that appears to have been drafted by a lawyer has rationalizations that weren't part of the decisionmaking process at issue. That's an issue that I may need to hear testimony on. I also -- but I do think that there's a substantial question, a substantial claim.

In addition, I find that extraordinary circumstances exist that make the grant of bail necessary to make the habeas

effective, to make the habeas remedy effective. To be blunt, we're living in the midst of a coronavirus pandemic. Some infected people die; not all, but some infected people die. If the petitioner is infected and dies, the case will be moot. The habeas remedy will be ineffective.

And being in a jail enhances risk. Social distancing is difficult or impossible. Washing hands repeatedly may be difficult. There is, it appears not to be disputed, one court -- one Plymouth County jail employee who has been infected, and there's a genuine risk that this will spread throughout the jail. Again, the petitioner is in custody with people charged with or convicted of crimes. He's not been charged or convicted of anything.

I've also considered what I ordinarily consider in making or reviewing bail decisions in criminal cases. There's no contention that the petitioner will be dangerous to any individual or the community if he's released on reasonable conditions.

ICE does contend that he would be a risk of flight. That is based on the fact that he missed one immigration hearing at which his removal was ordered and apparently did not tell ICE of his change of address. And he is facing a serious risk of being removed. He may not prevail on the habeas petition. And if he does, he may not get a provisional waiver.

However, there's no indication that the petitioner has

anyplace to go. Being among other people, say, in a homeless shelter is very dangerous, like being in a jail. There's no indication that he has any relatives or others who might take him in other than his wife. And I am ordering that he live with his wife in Lawrence, Massachusetts; that he stay in their residence, except if there is a medical need for him to leave; and, unless it's a genuine emergency, he would need the permission of ICE to leave. And he is to be on electronic monitoring, so if he leaves the residence when he hasn't been authorized to leave, ICE would know that and, if appropriate, could come back to me to revoke his release.

In addition, there are certain equities that favor the release of the petitioner. He's now been detained since September 4, 2019. On January 27, the motion was filed to enjoin his removal. As I indicated in the course of the argument, with the assent of petitioner's counsel, class counsel, ICE has repeatedly been given extensions of time to respond to the motion.

On January 31, 2020, the parties filed a joint motion to give ICE until February 14 to confer, and then on February 13, the respondents filed an unopposed motion for an extension of time to file their opposition until February 20, which I allowed. Then I was asked not to schedule a hearing in this case until after March 25 because Mr. Lyons would not be available from March 10 to 24. I accommodated that. And I was

told that local counsel, Ms. Piemonte, would be on trial until April 6. On March 19 I allowed the respondent's motion for respondents to file a sur-reply. And though it's possible, except for ICE asking for and receiving extensions of time to respond or file a sur-reply, that there would have been a hearing and a decision on this case earlier.

So essentially we're in a circumstance where an individual who has not been accused of any crime has been detained for -- I think it comes to about six and a half months. Part of that is because I've stayed his removal pending the decision on his motion to enjoin removal, but because of accommodations to ICE, that wasn't fully briefed until less than a week ago, and I had been asked to defer to Mr. Lyons' availability, which I did.

So for all of those reasons, I'm ordering that the petitioner be released no later than tomorrow, March 26, 2020, on the conditions I articulated and will memorialize in a brief order.

I'm ordering counsel for ICE to inform me when he has been released, and if there's some problem with implementing this order by tomorrow, you'll have to let me know promptly. Petitioners' counsel I'm directing, ordering, to inform the petitioner and his wife of my decision, including the requirements that he live with his wife and that he be on electronic monitoring. And he'll have to confirm for ICE, he'll have to provide ICE her address if they don't have it and

confirm her willingness to have her husband with her for the duration of this case.

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