INDEX OF EXHIBITS

EXHIBIT A

DECLARATION OF DR. JULIE DEAUN GRAVES

I, Julie DeAun Graves, declare as follows:

1. I am Associate Director of Clinical Services at Nurx, a practicing physician with board certification in Family Medicine, and I am a public health physician, previously serving as Medical Director for the Texas Department of State Health Services for the Houston region, as Medical Services Coordinator for the Texas Department of Aging and Disability Services, and as a medical consultant to the Texas Medical Board. I managed the H1N1 influenza outbreak for the Texas State Supported Living Centers and oversaw public health efforts for the Houston region (population 7 million) for Ebola virus, Zika virus, West Nile virus, highly pathogenic avian influenza, tuberculosis outbreaks, and natural disasters. I obtained my medical degree and completed a surgical internship then family medicine residency at the University of Texas Southwestern Medical School in Dallas, Texas. I earned a Master's degree in Public Health and a Doctor of Philosophy in Management, Policy, and Statistics at the University of Texas School of Public Health. I have practiced family medicine and public health since 1989, and in 2018-2019 I was Associate Professor and Vice-Chair for Education at Georgetown University School of Medicine. I attach a copy of my curriculum vitae.

2. COVID-19 is an illness caused by the SARS-CoV-2 virus, which is a coronavirus that was first detected in humans during the outbreak (now a pandemic) we are experiencing now. The Centers for Disease Control and Prevention reports that as of March 18, 2020 at noon, there are 7,038 cases in the United States, with some cases reported in every state in the US, and there are 97 deaths so far. The Texas Department of State Health Services reports 83 cases and two deaths as of March 18, 2020. The U.S. and Texas are in the early stages of the pandemic, and because there has been insufficient testing for cases, the reported cases numbers are low despite the high probability that there are many more infected individuals in the population. Spread is faster and more dangerous when people are in close quarters. People must maintain distance from others of six feet or more to reduce spread of the virus from person to person.

3. People with health conditions such as diabetes, asthma, emphysema, heart disease, kidney disease, pregnancy, cancer, HIV, and autoimmune diseases like lupus and rheumatoid arthritis are at higher risk for severe illness, complications, and death from COVID-19. People over age 60 have higher death rates, but severe cases of illness and deaths are reported in people of all ages. The ratio of cases of COVID-19 to deaths from this illness is much higher than for other contagious diseases like influenza.

4. The SARS-CoV-2 virus damages the lung tissue, which means that even those who recover need prolonged medical care and rehabilitation. They are likely to have permanent disability from loss of lung capacity. The heart itself can be infected, and kidneys and the nervous system can also be impacted and damaged permanently.

5. There is no vaccine and no treatment for COVID-19. We only have prevention as a tool to stop the pandemic. If we don't move people out of congregate settings, most of them plus the staff who work with them will become infected, and many will die or have permanent disability. People must be in small family groups and should distance 6-10 feet from anyone not in their family group. People should not be in large buildings full of many people, and people must practice thorough hand washing. If we don't do these two steps – distancing and hand washing – the pandemic will not end.

6. COVID-19 is transmitted from person to person by breathing in air that contains the droplets they've coughed or the virus they've shed, or by touching a surface with the virus on it, unless there is full personal protective equipment: mask, gloves, gown, plus thorough handwashing before putting on the equipment and after removing it.

7. As Medical Director for the Texas Department of State Health Services Houston region, I collaborated with the Department of Health and Human Services during disease outbreaks among children who were held in facilities in central and south Texas. I am familiar with these facilities and the conditions faced by people held and by those who work there. In August of 2019 I volunteered with a Catholic Charities facility in Laredo, Texas and provided medical care to people just released from detention in Customs and Border Patrol facilities. I observed the ill health, exhaustion, and malnutrition evident in these people. Additionally, because of my work as Medical Services Coordinator for the Texas Department of Aging and Disability Services overseeing health care in the State Supported Living Centers, which are congregate living settings, I am familiar with the risks to residents and staff of any infectious disease, and particularly those with high infectivity, such as this coronavirus SARS-CoV-2.

8. I have read and analyzed the March 18, 2020 Immigration and Customs Enforcement documentation found at https://www.ice.gov/covid19. The guidance regarding personal protective equipment is insufficient to maintain the health and safety of the people held and those who work in these facilities. The document states that Immigration and Customs Enforcement follows guidance from the Centers for Disease Control and Prevention regarding masks and other personal protective equipment. The Centers for Disease Control and Prevention guidance includes using bandanas, scarves, and other home-made protection when sufficient masks are not available. Unless every person with any respiratory symptoms and all workers who are in contact with more than one detainee are wearing properly fit-tested N-95 masks, they are not protected from spread of this

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

9. The March 18, 2020 Immigration and Customs Enforcement documentation states that there are no confirmed cases of COVID-19 in Immigration and Customs Enforcement facilities. However, there is no evidence that any testing for this virus has been performed. There cannot be confirmed cases without testing. The risk is very high that there are indeed unconfirmed cases in these facilities, and that detainees are not being provided with appropriate testing. This guidance document notes that new detainees are screened for risk of COVID-19. However, we are now in a pandemic, and all are at risk. Plus, detainees enter an area of risk when they enter a facility. Detainees who meet risk criteria are housed separately from others, but they are not quarantined alone, but instead held in groups. This does not meet quarantine standards. Also, the document notes that symptomatic detainees are transported to medical appointments with only a mask. This is insufficient. The masks should be N-95, and a thorough fit testing must be performed in order for this N-95 to protect others from an ill person's respiratory secretions. No protective equipment to prevent transmission from surfaces is in place. Those detainees who are transported out of the United States by airplane have not been tested for SARS-CoV-19 and are not transported in appropriate personal protective equipment.

10. Proper procedure in Immigration and Customs Enforcement facilities should be that all detainees and staff practice social distancing as delineated by the Centers for Disease Control and Prevention. Only family groups should be in a space that is sealed off from others, and these groups should maintain distance of at least six feet from other persons. All detainees should be informed about safety protocols and proper hand washing procedures and frequency and monitored to ensure that they are following these protocols and procedures.

11. Even if all of the recommendations made by Immigration and Customs Enforcement and that I have provided are followed, the conditions of detention are such that the detained families would still be at high risk. Because this virus is transmitted through droplets, through the air, and on surfaces, and because people who do not have symptoms but are infected transmit the virus to others, even one infected person in a facility, either a detainee or a staff member, can infect the majority of people in the facility. This is worsened by the crowded conditions in the facilities.

12. For the reasons above, in order to contain the unchecked spread of the COVID-19 virus, we must relocate as many people as possible out of institutional settings. This would also

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

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

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

Dr. Julie DeAun Graves

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

Current positions:

Family medicine and public health physician in private practice

Associate Director of Clinical Services, Nurx

Education:

06/1979 Bachelor of Arts, Rice University, Houston, Texas
Majors: Biology, Health and Physical Education

06/1983 Doctor of Medicine
The University of Texas Southwestern Medical School, Dallas, Texas

12/1992 Master of Public Health
The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas
Concentration: Health Services Organizations
Thesis: Preferences for Perinatal Health Decisions: A Critical Appraisal

12/2011 Doctor of Philosophy
The University of Texas Health Science Center (UTHealth) School of Public Health, Houston, Texas
Division of Management, Policy, and Community Health
Major: Health Policy
Minors: Management, Biostatistics
Dissertation: Analysis of Policy Issues Surrounding the Electronic Medical Record

Medical licensure:

State: Texas

License No: G5110

Initial Date: 08/23/1983

Renewal/Expiration Date: 02/28/2020

State: Wisconsin

License No: 53273

Initial Date: 06/23/2009

Renewal/Expiration Date: 10/31/2021

State: Alabama

License No: 12408

Initial Date: 10/22/1985

Renewal/Expiration Date: 12/31/1986

State: Nebraska

License No: TX-G5110

Initial Date: 07/20/1985

Renewal/Expiration Date: 07/26/1985

State: Florida

License No: ME134326

Initial Date: 10/25/2017

Renewal/Expiration Date: 01/31/2022

State: District of Columbia

License No: MD045899

Initial Date: 02/26/2018

Renewal/Expiration Date: 12/31/2020

State: Maryland

License No: D84791

Initial Date: 02/16/2018

Renewal/Expiration Date: 09/30/2020

Certifications:

American Board of Family Medicine: Certificate Number 1070893973

Date certified: 07/1989
Dates of Re-certification:
Jul 14, 1989 - Jul 13, 1995
Jul 14, 1995 - Jul 12, 2001
Jul 13, 2001 - Aug 01, 2008
Aug 02, 2008 - Apr 09, 2017
Apr 10, 2017 -12/2027

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

Advanced Trauma Life Support 01/2003-12/2019

Pediatric Advanced Life Support 01/2004-12/2017

Languages Spoken
English – mother tongue
Spanish – basic medical
German – basic

Previous Academic Appointments and Activities

03/2018-03/2019
Vice-Chair for Education, Department of Family Medicine, Georgetown University School of Medicine

05/2017-12/2017
Associate Professor of Epidemiology, University of Medicine and Health Sciences, St. Kitts and Nevis

06/2015-08/2019
Adjunct Associate Professor of Management, Policy, and Community Health, The University of Texas Health Science Center (UTHealth) School of Public Health

Lecturer: PH 3620, Principles and Practice of Public Health
Lecturer: PH 5220, Gender and Leadership

Preceptor: Occupational Medicine Residency program

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

06/2015-05/17
Faculty, Texas Department of State Health Services Preventive Medicine Residency program

Infectious Diseases and Chronic Disease Preventive Lectures Series Coordinator

06/2014
Visiting Faculty, Tanzania Training Center for International Health

03/2013-08/2014
Associate Professor of Behavioral and Clinical Medicine and Public Health, University of Sint Eustatius School of Medicine

Course director: Epidemiology, Medical Ethics, Biostatistics

09/2012-08/2013
Adjunct Assistant Professor of Epidemiology, The University of Texas Health Science Center (UTHealth) School of Public Health

Dissertation Committee Member, DrPH student Christina Socias (completed)

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

Course director and principal faculty, Medical Ethics

Faculty, Introduction to Clinical Medicine

01/2012-09/2012
Assistant Professor of Family and Community Medicine, The University of Texas Health Science Center at San Antonio, Texas

06/2009-08/2009
Graduate Teaching Assistant, The University of Texas Health Science Center (UTHealth) School of Public Health

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

11/2002-05/2005
Faculty physician, Austin Medical Education Programs, Family Medicine residency program, Austin, Texas

01/1995-12/1999
Clinical Assistant Professor of Family Medicine, Texas A&M University Brazos Valley Family Medicine residency program, College Station, Texas

11/1992-05/1995
Clinical Assistant Professor of Family Medicine, Baylor College of Medicine, Houston, Texas

Obstetrics fellowship co-coordinator

08/1989-08/1991
Assistant Professor of Family and Community Medicine, The University of Texas Houston Health Science Center

Founding course director, Family Medicine Clinical Clerkship

Co-author, HRSA Primary care training grant

Research Activities

01/2012-09/2012
ReACH Scholar, Center for Research to Advance Community Health, University of Texas Health Science Center at San Antonio
Project: Quality assurance using electronic health records
Principle Investigator: Barbara J. Turner, MD, MSED, MSCP
Internal funding.

01/2007-12/-2009
Research Associate, Health Policy Institute, University of Texas School of Public Health
Projects: Translational research applications of public policy analysis; Food oases
Principle investigators: Stephen Linder, PhD and Eduardo Sanchez, MD, MPH
Internal funding

01/1991-12/1992
Research Associate, Center for Health Policy Studies, University of Texas School of Public Health
Project: Health manpower analysis for primary care in Texas
Principle investigators: Virginia Kennedy, PhD and Frank Moore, PhD
Funding: Texas Higher Education Coordinating Board

08/1989-08/1991
Project staff, University of Texas Houston Health Science Center
Project: Cholesterol reduction with high rice fiber diets
Principle investigator: Mark E. Clasen, MD, PhD
Funding: National Rice Council

09/1988-06/1989
Principle investigator, McLennan County Medical Education and Research Foundation
Project: Obstetrical Practice by Texas Family Physicians
Funding: Texas Higher Education Coordinating Board

Governmental Public Health Practice

06/2017-3/2019
Consultant to Ministry of Health, St. Kitts and Nevis, for disaster preparedness and cannabis health effects

02/2015-05/2017
Regional Medical Director, Texas Department of State Health Services, Health Services Region 6/5S (Houston area, population 7 million)

01/2009-12/2011
Medical consultant, Texas Medicaid Office of Inspector General, Austin, Texas

01/2005-12/2012
Quality monitor and investigator, Texas Medical Board, Austin, Texas

09/2009-05/2011
Medical Services Coordinator for State Supported Living Centers, Texas Department of Aging and Disability Services, Texas (statewide)

Member, Institutional Review Board

05/2001-22/2002
Medical Consultant, Texas Department of Health, Children's Health and Infectious Disease Epidemiology and Surveillance, Austin, Texas (statewide)

Chair, Institutional Review Board, Texas Department of Health

06/1995-12/1999
Educational consultant, Texas WIC (Women, Infants, and Children) nutrition program

01/1994-12/1995
Utilization Review Physician, Lone Star Texas Medicaid managed care program

Clinical Experience

04/2005-02/2015 and 06/2017 – 3/2018
Private practice of family, hospitalist, and emergency medicine, Texas, Sint Maarten, Croatia, Carnival Cruises

09/2005 - 11/2005
Emergency Room Physician, U.S. Army MEDDAC, Wuerzburg, Germany Combat Support Hospital

01/2000-12/2001
Medical Director, Mother's Milk Bank at Austin (volunteer, co-founder)

09/1991-08/1992
Family physician, University of Houston student health service

09/1988-06/1989
Fellowship in Faculty Development, McClennan County Medical Education Research Foundation, Waco, Texas

06/1986-09/1988
Residency in Family Medicine, St. Paul Medical Center, Dallas, Texas

06/1985-05/1986
Locum tenens primary care and emergency medicine physician, CompHealth, Inc., Florida, Alabama, Nebraska, Texas

07/1984-05/1985
Residency training in Anesthesiology, University of Florida Shands Hospital, Gainesville, Florida

07/1983-06/1984
Internship in General Surgery, Parkland Memorial Hospital, Dallas, Texas

Private Sector

01/2009-12/2012
Principal, InGenius Strategies, LLC (health information technology consulting)

01/2005-12/2009
Consultant, Texas Medical Foundation Health Quality Institute (Medicare Quality Improvement Organization for Texas)

05/2005-08/2009
Chief Medical Officer, Practice IT, LLC (health information technology vendor)

01/1995-12/1996
Public policy advocacy, Texas Tobacco Education Project

Honors and Awards:

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

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

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

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

Bibliography

Textbook chapters

1. **Moy, Julie Graves**. "Cardiac Arrest", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

2. **Moy, Julie Graves**. **"**Advanced Trauma Life Support", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

3. **Moy, Julie Graves**. **"**Domestic Violence", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

4. **Moy, Julie Graves**. "The Limping Child", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

5. **Moy, Julie Graves**. "Sickle Cell Anemia", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

6. **Moy, Julie Graves**. "Lymphomas and Leukemias", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

7. **Moy, Julie** Graves. "Common Problems in the Newborn", in Swanson's Family Practice Review, 6th Edition. Philadelphia: Elsevier Mosby, 2008.

8. **Moy, Julie Graves**, Pfenninger, John. "Peripheral Nerve Blocks and Field Blocks," in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994, 2002.

9. **Moy, Julie Graves**. "Induction of Labor," in Rakel RE. Conn's Current Therapy. WB Saunders, 1997.

10. **Moy, Julie Graves**. "Development of Clinical Guidelines," in Mengel M, Fields S (eds.). Guide to Clinical Expertise. New York: Plenum Press, 1996.

11. **Moy, Julie Graves.** "Bites and Stings," in Taylor RB (ed.). Family Medicine: Principles and Practice. New York: Springer-Verlag, 1994.

12. **Moy, Julie Graves.** "Nasogastric Tube and Salem Sump Insertion," in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri: Mosby, 1994.

13. **Moy, Julie Graves**. "Informed Consent," in Pfenninger JL, Fowler GC (eds.). Procedures for Primary Care Physicians. St. Louis, Missouri, Mosby, 1994.

14. Duiker SS, **Moy, Julie Graves**. "Dyspareunia," in Griffith HW, Dambro M (eds.). The Five-Minute Clinical Consult. Philadelphia: Lea and Febiger, 1993 – 1997.

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

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

Peer-reviewed publications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Letters to the Editor

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

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

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

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

Service on State and National Panels and Committees:

Health Policy Panel Membership

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

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

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

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

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

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

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

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

1. Agency for Health Care Policy and Research Pressure Sore Panel

2. National Heart, Lung, and Blood Institute Panel on Treatment of Asthma During Pregnancy and Lactation

3. National Heart, Lung, and Blood Institute Guidelines for the Diagnosis and Treatment of Asthma

4. American Academy of Ophthalmology Policy on Strabismus

5. Expert Panel on Preventive Services paper on Iron Supplementation During Pregnancy

6. Expert Panel on Preventive Services paper on Testing for D Isoimmunization in Pregnancy

7. American Academy of Pediatrics practice parameter on Treatment of Acute Asthma Exacerbation in Children

8. American Academy of Pediatrics practice parameter on Hyperbilirubinemia in the Newborn
Service on Medical School Committees:

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

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

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

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

Editorial Review for Medical Journals:

2018-present Peer Reviewer, American Family Physician

2017-present Peer Reviewer, Texas Public Health Association Journal

2001-2016 Peer Reviewer, Journal of Family Practice

2010-2017 Peer Reviewer, Family Practice Management

1997 Peer Reviewer, Feminist Economics

1995-1998 Editorial Review Board, Journal of Human Lactation

1994-1997 Peer Reviewer, American Family Physician

1993-2013 Peer Reviewer, Texas Medicine

1992-1997 Peer Reviewer, Archives of Family Medicine

1992-1995 Peer Reviewer, Family Medicine

1990-1993 Editorial Committee, Texas Medicine

1988-1989 Editor, Texas Family Physician "Resident Forum"

Presentations at Scientific Meetings:

1. Garrison R, **Graves J.** An Analysis of Barriers to Care for Patients Requiring Rabies Post-exposure Prophylaxis in Texas Department of State Health Services Region 6/5S. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

2. Ramsey J, Mayes B, **Graves J.** Demographics of Child Fatality in Rural Southeast Texas. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas (poster)

3. Jones R, Abrego D, Deeba R, Varghese C, LaBar C, Mayes B, **Graves J.** Public Health Prevention Needs for Domestic Minor Sex Trafficking in Rural Southeast Texas Counties. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

4. **Graves J.** Vector-borne Disease Public Policy. South Texas Tropical Medicine and Vector Borne Disease conference. February 24, 2017. South Padre Island, Texas

5. Martinez D, Jin S, Milligan S, Haynie A, Arenare B, Wiseman R, Weil L, Lozano C, Johnson T, **Graves J**. Investigation of a healthcare associated Hepatitis A cluster in and nearby Harris County, Texas. Council of State and Territorial Epidemiologists Annual Meeting. June 2017. Anchorage Alaska (poster).

6. Lin H, Weil L, Evans D, Shaw D, Rosen G, **Graves J**. Regional Epidemiology Coordination Plan: effective use during a multijurisdictional outbreak investigation. Texas Public Health Association 92nd Annual Education Conference, April 2016, Galveston, Texas

7. Rosen G, Lin H, Swanson K, Shaw D, Weil L, Evans D, **Graves J.** Local challenges to state policy: Evaluating the interim guidance for monitoring and movement of persons with potential Ebola Virus exposure in Southeast Texas --October-December, 2014. American Public Health Association Annual Meeting, October 2015, Chicago, Illinois.

8. **Graves J.** Health Information Technology Policy in Germany, Switzerland, and Austria: Lessons for US Policy Makers. American Public Health Association Annual Meeting, San Diego, California, October 2012

9. **Graves J,** Sanchez E. Meeting the Health Needs of the Emerging Majority: Applying Lessons Learned from Border Health Programs to Eliminate Health Disparities throughout the U.S. American Public Health Association Annual Meeting, San Diego, California, October 2008

10. **Graves J,** Aday L. Decision Analysis and Preferences for Perinatal Health States. Agency for Health Care Policy and Research Third Primary Care Conference. Atlanta, Georgia, January 1993

11. **Moy, Julie Graves**, Susman J, Berg A. Critiquing Clinical Policies. Society of Teachers of Family Medicine Annual Meeting, San Diego, California, April 1993

12. **Moy, Julie Graves,** Schindler J, Duiker SS. Teaching Ambulatory Care in the Urban Setting, American Association of Medical Colleges Southern Group for Educational Affairs, Houston, Texas, April 1991

13. **Moy, Julie Graves**, Clasen ME, Donnelly J. Implementation of a Required Third year Clerkship in Family Medicine after Legislative Directive. Society of Teachers of Family Medicine Predoctoral Education Conference, San Antonio, Texas, February 1991.

14. **Moy, Julie Graves**, Goertz R. Legislative Directive for a Third year Family Medicine Clerkship. Society of Teachers of Family Medicine, Seattle Washington, May 1990.

15. Conard S, Dahms L, **McCraney, Julie Graves.** Stress in Residency: External Causes, Manifestations, and Impairment in Family Medicine as Compared to Other Specialties. Texas Academy of Family Physicians, Austin, Texas, September 1988, first place; also at American Academy of Family Physicians, Los Angeles, October 1988.

Invited Lectures

1. The US Health Care System in Transition. University of Medicine and Health Sciences Health Policy Lecture Series. July 13, 2017. Basseterre, St. Kitts and Nevis.

2. Legislative Issues Regarding Syndromic Surveillance. Texas Health Information Management Systems Society Legislative Conference. April 12, 2017, Austin, Texas.

3. Cross-Jurisdictional Coordination for Super Bowl LI Planning. Local Health Authorities Symposium. Texas Public Health Association 93rd Annual Meeting. March 27, 2017, Fort Worth, Texas

4. Texas Syndromic Surveillance System. Health Information Management Systems Society, Austin Chapter, August 9, 2016

5. A Congressional Forum on the Zika Virus and a Discussion of an Action Plan for Houston and Harris County. Good Neighbor Health Clinic, Houston, March 10, 2016.

6. Telemedicine for Children with Special Health Care Needs. Caring for Children with Special Health Care Needs in Medicaid Managed Care, Texas Health and Human Services Commission, Austin, Texas, March 8, 2002. With Nora Taylor Belcher

7. Medicaid and Managed Care. Women in Government Forum on Medicaid, Austin, Texas, September 16, 1995.

8. Managed Care and Managed Competition. Southeast Texas Chapter of the International Patient Education Council, University of Texas MD Anderson Cancer Center, June 2, 1993.

9. AIDS and Adolescents: HIV Policy Concerns. National Conference of State Legislatures Women's Network, Mobile, Alabama, May 20, 1993.

10. Vaginal Birth after Cesarean. Visiting Professor in Perinatal Health, University of Kansas School of Medicine Perinatal Conference, Kansas City, Kansas, April 3, 1992.

11. The Development of Medical Specialties in America. History of Medicine Lectures, University of Texas Houston Health Science Center, April 25, 1991.

Presentations at Professional Development Courses

1. Analysis of Policy Issues Surrounding the Electronic Medical Record. Grand Rounds. University of Texas Health Science Center at San Antonio. October 14, 2011. One hour Category I credit.

2. Barriers to Preventive Care for Women with Disabilities. Center for Health Disparities Annual Conference, University of North Texas Health Science Center, Ft. Worth, Texas, May 8, 2010. One hour Category I credit.

3. Clinical Indicators in Medicare's Hospital Quality Improvement Project. Houston, Texas. January 13, 2006. One hour Category I credit.

4. Recent Changes to Texas End-of-Life Care Law. St. David's Medical Center, Austin, Texas. October 12, 2004. One hour Category I credit, one hour Texas Ethics credit.

5. Aggressive Treatment of Type II Diabetes: What's New in Type II Diabetes and Improving Chronic Disease Management Care with a Systems Approach. Texas Academy of Family Physicians. El Paso, Texas, May 2002. Two hours Category I credit.

6. Update in Medical Ethics and Professionalism. Central Texas Continuing Education Consortium. Austin, Texas, October 1999. One hour Category I credit.

7. Breastfeeding Update. Grand Rounds. Columbia Bayshore Medical Center, Pasadena, Texas, July 16, 1998. One hour Category I credit.

8. Breastfeeding in Special Circumstances. American Academy of Family Physicians Annual Session September 17, 1997, Chicago IL, 1 hour prescribed credit. Taught again in Annual Session in 1998.

9. Breastfeeding Update. Presbyterian Hospital Combined Obstetrics/Pediatrics conference, April 1997, 1 hour AMA Category I credit.

10. Intensive Course in Breastfeeding: Lactation Management Workshop for Physicians. April 24, 1996, Houston, Texas. Four hours AAFP credit. Taught again Harlingen, Texas; Tyler, Texas; San Antonio, Texas, Dallas, Texas, Sugar Land, Texas in 1996, 1997, with Linda Zeccola, Tom Hale, Joanie Fischer, and Maryelle Van Landen

11. Intensive Course in Breastfeeding. March 11, 1996, Midland, Texas. Four hours continuing nursing education credit. Taught again in Gallup, New Mexico and Boise, Idaho.

12. Breastfeeding: Improving the Support System. Hermann Hospital/UT Houston Medical School Annual Perinatal Conference, Houston, Texas June 1996, 1 hour AMA credit.

13. Breastfeeding Update. Women's Hospital, Houston, Texas, September 1996, 1 hour AMA Category I.

14. Breastfeeding: Enlightening the Myths. Abilene Perinatal Conference, October 1996, 1 hour AMA Category I credit.

15. Family Oriented Prenatal Care. Baylor College of Medicine Advances in Family Medicine. January 20, 1995. 1/2 hour prescribed credit.

16. American Academy of Family Physicians Clinical Policies Training Course. San Diego, California, April 1993. 9.5 hours prescribed credit, with Hanan Bell

17. Preference/ Utility Assessment in Outcomes Research. Agency for Health Care Policy and Research Third Primary Care Conference, Atlanta, Georgia, January 10, 1993. 1 hour prescribed credit.

18. Hormone Replacement Therapy. Clinical Recommendations Update at American Academy of Family Physicians Scientific Assembly, Orlando Florida, October 1993. 2 hours prescribed credit.

19. Problems and Solutions in Integrating Clerkship Teaching with Residency Education. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, May 18, 1990. 1 hour prescribed credit, with Donald Koester

20. The Status of Obstetrical Practice by Texas Family Physicians: Implications for Residency Training. McLennan County Medical Education and Research Foundation Program Management Conference, Austin, Texas, February, 1989. 1 hour prescribed credit.

21. The Genogram in Prevention. University of Texas Houston Health Science Center/ Texas Academy of Family Physicians Prevention for the Nineties Conference, Houston, Texas, October 30, 1989. 1 hour prescribed.

Professional Organizations:

American Public Health Association 1992-present
2020-2023 Governing Councilor
2015-2016 Joint Policy Committee member; Co-chair, 2016
2016 Executive Board member, ex officio
2014-2017 Submission Review for Annual Scientific Meeting
2012-2016 Science Board member; Chair, 2016
Medical Care Section (Mentoring Chair 2018)
International Health Section

Florida Public Health Association 2019-present

Florida Medical Association 2019-present

Travis County Medical Society 1995-2014
1998-2001 Committee on Legislation; Chair 1999-2000
1996-1999 Alternate Delegate to Texas Medical Association

Harris County Medical Society 1989-1995 and 2015-2016
2015-2016 Committee on Communication and Public Health
2015-2016 Emergency Care Committee, *ex officio*
1995 Delegate to Texas Medical Association
1994-1995 Board of Medical Legislation
1990-1995 Committee on Membership and Medical Precepts
1992-1993 Executive Board, Central Branch
1991-1994 Alternate Delegate to Texas Medical Association
1991 Medical Student Committee
1991 Chair, Young Physicians Section
2015–present Committee on Communications and Public Health

Texas Medical Association 1987-2016
1995-2001 TexPAC (political action committee) Board of Directors
1994 Task Force on Hospital Staff-County Medical Society Relations
1993-1994 *ad hoc* Committee on Practice Parameters
1998 Council on Public Health
1991-1992 *ad hoc* Committee on International Medical Graduate Issues
1990-1994 TexPAC (political action committee) Vice-chairman
1990-1991 Young Physicians Governing Council
1989 Chairman, McLennan County MediCaring Task Force
1989-1991 Committee on Manpower
1989 Council on Socioeconomics
1987-1988 Committee on Health Insurance

American Medical Association 1987-1999, 2006-2008, 2010 -2011
1991 Executive Committee and Founding Member, Women's Caucus
1989-1994 Medical Schools Section, Delegate for University of Texas Health Science Center, Houston

American Academy of Family Physicians 1987-present
1993-1999 Peer Reviewer, Home Study/Self-Assessment Program
1991-1995 Task Force on Clinical Policies for Patient Care; Executive Committee
1993-1994 Vaginal Birth after Caesarean Section Policy Team

Texas Academy of Family Physicians 1987-2016
1997 -1998 Task Force on Governance
1997 Task Force on Computers
1996 Task Force on Health System Reform
1997 Committee on Public Health and Scientific Affairs Chairman, 1995-1997
1994-1996 Committee on Legislation and Public Policy Vice-chair, 1996
1990 Vice-Chairman, Student Affairs Committee

Names used due to marriage:

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

Address

[redacted]

Email:
[redacted]

Telephone

[redacted]

EXHIBIT B

Timothy P. Fox (CA Bar 157750)
tfox@creeclaw.org
Elizabeth Jordan*
ejordan@creeclaw.org
CIVIL RIGHTS EDUCATION AND ENFORCEMENT CENTER
1245 E. Colfax Avenue, Suite 400
Denver, CO 80218
Tel: (303) 757-7901
Fax: (303) 872-9072

Lisa Graybill*
lisa.graybill@splcenter.org
Jared Davidson*
jared.davidson@splcenter.org
SOUTHERN POVERTY LAW CENTER
201 St. Charles Avenue, Suite 2000
New Orleans, Louisiana 70170
Tel: (504) 486-8982
Fax: (504) 486-8947

Stuart Seaborn (CA Bar 198590)
sseaborn@dralegal.org
Melissa Riess (CA Bar 295959)
mriess@dralegal.org
DISABILITY RIGHTS ADVOCATES
2001 Center Street, 4th Floor
Berkeley, California 94704
Tel: (510) 665-8644
Fax: (510) 665-8511

Attorneys for Plaintiffs (continued on next page)

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

FAOUR ABDALLAH FRAIHAT, *et al.*,

Plaintiffs,

v.

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

Defendants.

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

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

Date: March 24, 2020

William F. Alderman (CA Bar 47381)
walderman@orrick.com
Jake Routhier (CA Bar 324452)
jrouthier@orrick.com
ORRICK, HERRINGTON &
SUTCLIFFE LLP
405 Howard Street
San Francisco, CA 94105
Tel: (415) 773-5700
Fax: (415) 773-5759

Michael W. Johnson**
mjohnson1@willkie.com
Dania Bardavid**
dbardavid@willkie.com
Jessica Blanton**
jblanton@willkie.com
Joseph Bretschneider**
jbretschneider@willkie.com
WILLKIE FARR &
GALLAGHER LLP
787 Seventh Avenue
New York, NY 10019
Tel: (212) 728-8000
Fax: (212) 728-8111

Maia Fleischman*
maia.fleischman@splcenter.org
SOUTHERN POVERTY LAW
CENTER
2 South Biscayne Boulevard
Suite 3750
Miami, FL 33131
Tel: (786) 347-2056
Fax: (786) 237-2949

Christina Brandt-Young*
cbrandt-young@dralegal.org
DISABILITY RIGHTS
ADVOCATES
655 Third Avenue, 14th Floor
New York, NY 10017
Tel: (212) 644-8644
Fax: (212) 644-8636

Mark Mermelstein (CA Bar 208005)
mmermelstein@orrick.com
ORRICK, HERRINGTON &
SUTCLIFFE LLP
777 South Figueroa Street
Suite 3200
Los Angeles, CA 90017
Tel: (213) 629-2020
Fax: (213) 612-2499

Leigh Coutoumanos**
lcoutoumanos@willkie.com
WILLKIE FARR &
GALLAGHER LLP
1875 K Street NW, Suite 100
Washington, DC 20006
Tel: (202) 303-1000
Fax: (202) 303-2000

Shalini Goel Agarwal
(CA Bar 254540)
shalini.agarwal@splcenter.org
SOUTHERN POVERTY LAW
CENTER
106 East College Avenue
Suite 1010
Tallahassee, FL 32301
Tel: (850) 521-3024
Fax: (850) 521-3001

Maria del Pilar Gonzalez Morales
(CA Bar 308550)
pgonzalez@creeclaw.org
CIVIL RIGHTS EDUCATION
AND ENFORCEMENT CENTER
1825 N. Vermont Avenue, #27916
Los Angeles, CA 90027
Tel: (805) 813-8896
Fax: (303) 872-9072

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

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

I. BACKGROUND AND QUALIFICATIONS

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

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

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

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

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

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

II. HEIGHTENED RISK OF EPIDEMICS IN JAILS AND PRISONS

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

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

9. Reduced prevention opportunities: 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,

[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.

chronic lung disease, chronic liver disease, and lower immune systems from HIV.

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

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

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

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

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick

and do not show up to 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

[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.

our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

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

[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

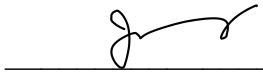
[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

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

March 22, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

[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.

EXHIBIT C

DECLARATION OF BRIDGET CAMBRIA, ESQ.

I, Bridget Cambria, declare and say as follows:

1. My name is Bridget Cambria, Esq. and I am an attorney licensed to practice in the State of Pennsylvania since May of 2007. This declaration describes my experiences and observations working with clients detained in an ICE family residential center, including detention practices and conditions and, in particular, issues concerning the detention of parents and children in the Berks Family Residential Center during the COVID-19 pandemic, their concerns about contracting a life-threatening illness in detention and the conditions of detention which threaten the lives of the families in immigration family detention in Pennsylvania.

2. For more than 12 years, I have exclusively practiced immigration law, working with children, families and adults, both in the detained and non-detained settings. In my practice, I have represented immigrants, children and families before Immigration Courts nationwide, the Board of Immigration Appeals, Federal District Courts and the Third Circuit Court of Appeals. I am a graduate of the Roger Williams School of Law, where my studies focused on immigration and public interest law. Prior to law school, on or about 2002, I was employed by the County of Berks as a staff member at the Berks County Residential Center (hereinafter "BCRC," previously and alternatively known as the "Berks County Youth Center", "Berks Family Shelter", or the "Berks Family Detention Center").

3. Currently, I am an attorney with, and the Executive Director of, Aldea – The People's Justice Center ("Aldea"), a non-profit located in Reading, Pennsylvania in the County of Berks. Our organization, Aldea, offers universal representation to families detained at the Berks County Residential Center in Leesport, Pennsylvania. In the last five years, we have represented more than one thousand parents and children who have been detained in family detention in the BCRC.

4. In the course of employment, I have regular occasion to observe, and therefore am familiar with, the policies and practices of United States Immigration and Customs Enforcement ("ICE") toward the detention, release, and treatment of children and parents in family detention generally and the Berks County Residential Center. I have also had the opportunity to observe detention practices and detention conditions for families detained by ICE in Pennsylvania.

5. Aldea maintains a near daily presence on the ground at the BCRC providing pro bono legal services to detained families at no cost to ensure that all detained families and children have access to legal services in immigration matters, which often times is a matter of life and death. Families detained at the BCRC are seeking protection from persecution and torture and are actively pursuing asylum, withholding of removal and protection under the United Nations Convention Against Torture. Although the majority of families detained in Berks are from Mexico, Guatemala, Honduras and El Salvador, families in the BCRC come from all over the world. Other countries currently represented in the detained population at Berks include also families from Haiti and India.

6. Prior to arriving at Berks, the vast majority of families are first detained in a "*hielera*" ("icebox") prior to arriving at Berks. Our clients frequently report they were crammed into a large, cold cell for multiple days without access to hot meals, showers, toiletries, medical care, and beds while in CBP custody. Following this time in unsanitary conditions in CBP the families are transported to airports and flown to the BCRC. Often we observe families and children arriving to the facility ill due to the poor conditions in CBP custody, and often children and families fall ill shortly after arriving at the detention center as a result of the same.

Detention Practices at the Berks County Residential Center

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

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

8. I have also had an opportunity to tour the BCRC facility in my capacity as a Flores monitor. Our staff continue to provide services during the COVID-19 outbreak as we are obligated by the EOIR to provide legal representation in Immigration Courts that remain open. Detained Immigration Courts have not shuttered during the pandemic, therefore our clients, detention centers, and our employees remain at risk.

9. The BCRC detains mothers, fathers and children. The BCRC detains children of all ages, as young as an 11-day-old newborn through children aged 17 years of age. The current population of Berks consists of children as young as 6 months old to children who are teenagers. The BCRC can detain up to 96 persons at one time. As of this writing, we can estimate that about 50 mothers, fathers and children are detained at the BCRC, a facility that consists of one building where the detainees are in close quarters. The placement determination of families in the BCRC, rather than placement in liberty, is made by ICE. The majority of families apprehended by the Department of Homeland Security ("DHS") are

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

10. Family detention by the DHS occurs only in the BCRC in Leesport, Pennsylvania, the South Texas Family Residential Center in Dilley, Texas and the Karnes County Residential Center, in Karnes, Texas. A family cannot be detained in any other facility in the United States. For that reason, families are transported from every part of the United States into the family detention centers in Texas and Pennsylvania. We receive families from the Southern Border, from interior apprehensions by ICE throughout the United States and apprehensions at the Northern Border.

11. Not a single family in the Berks County Residential Center has a criminal record. Every family in the BCRC is an asylum seeker, with a pending proceeding with the Asylum Office or the Executive Office for Immigration Review. Every family is considered a "civil detainee." Every detained family would be subject to the same civil immigration proceeding whether in detention or outside of detention.

12. Routinely, detained families are released from the BCRC by ICE and placed with their families, friends and sponsors who reside in the United States without necessary intervention by a Judge or the requirement of payment of a monetary bond given the particular vulnerability of children, to ensure proper care of children outside of a detention environment, and because asylum-seeking detainees can provide a fixed address wherein the family will reside while abiding by alternatives to detention, including electronic monitoring, phone monitoring, in person ICE supervision appointments and/or participation in an intensive supervision appearance program.

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

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

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

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

16. Throughout the day, detained parents and children are mandated to congregate together, including three census periods, three lunch periods and times when free movement is prohibited. At no point is a family permitted to leave the building into the recreation area, except where given permission and at no point may a family leave the facility of their own choosing without being under the threat of federal criminal arrest.

17. Census requires detainees to report to the bedroom floor courtesy desk as a family to check in from 6:30am TO 7:30am 3:00pm TO 4:00pm 7:30pm TO 8:00pm. Failure to comply results in discipline. *[See Handbook page 15].*

18. Meals are provided in a single dining room three times a day, for both detained families and employees of the Berks facility. The families currently report more than 60 people are in the dining room during meal periods. Detained families, including small children, are required to be present in the dining room from: 7:30am to 8:00am 12:00pm to 1:00pm 5:30pm to 6:30pm. *[See Handbook Page 17.]*

19. The BCRC has a medical unit which is operated by Immigration Health Services Corps. There is no pediatrician nor gynecologist. A doctor is not present in the facility at all times, but comes and goes from the facility. All medical decisions for parents and children are made by the medical unit, including diagnosis, treatment, over-the-counter medication, and whether a parent or child should receive a test or visit a hospital.

20. Detained families are not allowed free movement throughout the BCRC or in recreation at various times, including after 8PM, and during all eating periods. Estimated times when detained families are permitted in outside recreation areas are 8:30AM to 11:30AM, 1:30PM to 4:30PM, and 6:30PM until the sun begins to set, however, they are not permitted outside without a guard escort or observation. At 8:00PM each day, all detained families are restricted to the second floor and no longer permitted even supervised free movement.

21. Children are to be in the company of their parents at all times.

22. In Family Residential Centers, parents are not responsible for determinations as to the care of their children. Parents cannot determine when their children wake up, what they eat or if they need to go to a hospital. Parental decisions are made for children, by the facility procedures, the guards within the facility and by ICE themselves. Children are told when they can and cannot play, when they can or cannot be outside, when they can eat and what they eat, and what happens when they misbehave – by the facility and not their parents. Medical decisions are not made by parents, either. Those decisions are made by ICE medical personnel or County facility staff.

23. Finally, at the BCRC, few employees speak Spanish. If a detainee has a problem, they must make a language service request, a guard must take them to a telephone to connect with an interpreter by phone, and an interpreter must be available. This arrangement does not permit adequate care of children, especially during emergencies. In a pandemic, the lack of in person interpreters in facilities that detain immigrants threatens the lives of the parents and children they detain. There is no way to communicate an emergency to a staff member quickly if neither the detainee nor the staff understands what is being said. This is unacceptable in an environment with children during the COVID-19 outbreak.

Detention Conditions at the BCRC During the COVID-19 Pandemic

24. I have had the opportunity to interview the detainees about their concerns and worries with the outbreak of the COVID-19 pandemic. The families are scared.

25. It is impossible for detained parents and children at the BCRC to practice social distancing—remaining 6 feet from others— as has been recommended to combat the COVID-19 pandemic. Based upon my observations at Berks, it would be impossible for detained individuals to create the distance between themselves and other detainees necessary to protect themselves. Detainees are forced to sleep in close quarters with others, share crowded bathrooms, and are forced to congregate in small communal areas. There are no more than two floors of permitted movement space for every single detainee limited to a handful of small rooms.

26. Clients of Aldea are very concerned that they will be exposed to COVID-19 and that they lack access to appropriate testing or medical treatment services while in detention. This is exacerbated by the fact that they cannot make medical decisions for themselves or their children. Without exception, each family interviewed by Aldea has reported that their children are currently ill, or were recently ill. Without exception, the families advised knowing about the outbreak only through news reports and are upset that the facility has not advised them the reality of what is happening on the outside of detention.

27. Detainees report that children and parents were not educated about the COVID-19 outbreak. They were not advised of different processes or procedures employed by the facility to prevent spread. They report a sign was posted saying “Wash your hands” in Spanish, but that other posters were in the English language and they are unable to read them. One detained family reported they were told to “cough in their elbow” and that was all.

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

29. Detainees do not have gloves or masks. Upon observation, staff was not wearing masks. Residents reported that the staff did use gloves when treating the detained families. Detainees only have access to gloves when they clean. They are paid $1 dollar a day to participate in a voluntary work program which, in part, cleans the facility. Upon observation there is no outside cleaning service. Cleaning is conducted by the families and the shelter care counselors of the BCRC.

30. Families expressed great concern about the health of their children. They express that they see staff of the facility spray cleaning product throughout a room, but do not wipe anything. They state they see the staff spray cleaning product directly on top of the children's toys, that both ill and well children play with toys, and parents fear that children often touch many things and put toys in their mouth, spreading germs.

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

32. Families report that children who show symptoms like constant cough, fever, sore throat, lethargy, congestion, difficulty breathing or sleeping, lack of appetite often go untreated. When treated, they are only provided Tylenol and it takes much time to receive actual medicine. Often, families report they are told the problem is allergies and that is all. This is true even in the time of the COVID-19 pandemic. Two days prior to this writing, Aldea staff requested "cough syrup" for a two-year-old boy who has a persistent cough and upon appearance was visibly ill. We requested the medicine when asked to inquire by client, as is often the case when children are ill for a prolonged time without treatment. Upon request to we were asked "What is cough syrup?" Then upon speaking with a caseworker to continue to ask for cough medicine, we were advised that we could not ask him that it was medical's decision, and when we asked to fill out a resident request form for cough medicine, were told that that such a request didn't exist, despite such requests being available pursuant to the detainee handbook. *[See Handbook Page 8]*

33. Families often face an impossible wall to receiving medical care in detention, which rings the alarm to legal service providers as to what will happen when the pandemic hits the detained population. It will result in a threat to the lives of men, women, parents and children.

34. As of this writing, we are unaware of any parent, child or employee at the BCRC who has been tested for COVID-19, this is despite the fact that the families and children do have cold and flu-like illnesses.

35. The facility can, and has, isolated families at different times. During medical isolation in detention, a parent is isolated with their children. They are isolated together even when only one of the members of the family unit is ill. There is no physical capability to medically quarantine everyone.

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

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

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

_____

Bridget Cambria, Esq.

EXHIBIT D

Berks Family Residential Center

Resident Handbook

1040 Berks Road
Leesport, PA 19533
610.396.0310

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

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

RESIDENT REQUESTS

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

CONTACTING IMMIGRATION

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

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

CASEWORKERS

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

LIVING ARRANGEMENTS

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

BEDROOMS

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

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

CHILDREN'S BEDTIMES

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

OVERNIGHT CHECKS

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

FREE MOVEMENT

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

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

LAUNDRY

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

PERSONAL HYGIENE

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

ALLOWABLE PERSONAL PROPERTY

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

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

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

RESIDENT CENSUS

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

6:30am TO 7:30am
3:00pm TO 4:00pm
7:30pm TO 8:00pm

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

THE CENTER LAYOUT

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

Activity Floor (A Floor):

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

Bedroom Floor (B Floor):

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

MEALS

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

Breakfast 6:30am -8:00am
Lunch 12:00pm -1:00pm
Dinner 5:30 pm – 6:30 pm

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

7:30am to 8:00am
12:00pm to 1:00pm
5:30pm to 6:30pm

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

KITCHENETTES

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

SPECIAL DIETS

Therapeutic/medical diets shall be prepared and provided according to the orders of the Center medical department physician. Religious diets shall be prepared and provided for residents whose religious beliefs require the adherence to religious dietary laws. Residents are required to meet with the Center Chaplain for religious diet approval. See the section on the Chaplain for more information.

EXHIBIT E

SWORN STATEMENT OF P.M.

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

1. My name is P.M. I am from Haiti. I am detained at the Berks detention center with my wife, M.N. and our 2 -year-old child, H.M.N.

2. We have been detained by Immigration since March 11, 2020, and detained at Berks since March 18, 2020.

3. We are still six families that are detained here, waiting every day to hear what is going to happen to us during this crisis.

4. Since we arrived at Berks County Residential Center on March 18 along with my wife and my two-year-old daughter, my child has been severely sick, and my wife and I have reported it to the medical staff every day since we arrived.

5. She has bumps all around her mouth, chin and lips. Sometimes they bleeds. Her throat is severely swollen so that she can't keep any food inside. She has been feverish. Even though we reported this to the medical staff every day, they did not start giving her medication until March 30, 2020.

6. But the medication did not help. Wednesday, April 1, they took us to an outside medical facility. At that hospital, we had to wear protective gear, gloves and masks, while being there.

7. At Berks, we are not given gloves or mask to wear. The only time that we are given gloves are the gloves we receive when we are cleaning the facility. The staff does not wear gloves or masks. They only wear gloves when we are being served food. When we asked for these things, we were told that it wasn't necessary.

8. The new medication that the outside doctors prescribed to my daughter on Thursday, April 2, is helping with the bleeding and the bumps.

9. My daughter is not the only one who is sick at the facility. All of the families that have come and left have had not been feeling well.

10. Last week, one of the other men drank the milk they serve in the fridge. He started having rashes and big swollen bumps all over his body. At the same time, my own child started coughing blood after drinking the same milk. We looked at the carton and the milk were expired. The staff were not concerned about this at all.

11. The detention center has made a few changes, but only in the past few days. Since 2 to 3 days ago, I noticed they changed the hand soap.

12. There are two recent posters, one talks about washing hands, and the other one talks about social distancing. They were hung on the wall a couple of days ago.

13. But nobody has yet come to talk to us about this pandemic. The things we hear and learn about COVID-19 are all from the news channels on TV. We hear about social distancing, but how can we do that when we are all detained together in one building? We all eat all our meals together in the same room. We spend our time together in the same few spaces.

14. The staff, who come and go from the facility, are always around us. We cannot even take a shower without one of them sitting outside the door.

15. We are all confined in a small space and there is no way to distance ourselves from other families or the staff.

16. There are less staff working at the facility as in now, but they still come and go. We are all detained here together, with our children and no way to leave. We are just legally seeking asylum, and have done nothing wrong.

17. We, the detained families, are still in charge of cleaning the bathrooms and bedrooms in the morning, and the playroom for kids in the afternoon. The only time we are offered gloves is during the cleaning process. I have not noticed the staff doing more cleaning then usual. And we still only clean these areas one time per day. We all share the bathrooms and they are not cleaned extra or in between uses.

18. On Wednesday, one male and one female came inside the facility and started recording us with their phone camera. We didn't want to be recorded, because nobody told us what this is about and what is the goal behind these videos. We were not feeling comfortable and we tried to avoid where the camera is. We asked to have our privacy respected because we are seeking asylum. If they want to video us, they should video our conditions to show that we need to be free from this place for ourselves and our children to be safe.

19. No one here speaks my language, and it is very hard to communicate and to express our feelings about being detained when it is so dangerous. I worry for my wife and my daughter, who are not well and are terrified. We are asking for help to stay alive.

20. We have close family in the United States who will receive us, I do not know why our lives are being risked at this moment.

This statement was prepared with me in my native language of Haitian Creole. I understood and agreed with the contents before signing. I also give my permission to have my signature electronically signed.

/s/P.M.
_____

Date: April 5, 2020

EXHIBIT F

SWORN STATEMENT OF G.S.C.

I, G.S.C., herby swear and attest, under the penalties of perjury, that the following is true and correct to the best of my knowledge:

1. My name is G.S.C.. I am detained at the Berks detention center with my wife, M.C., and our two daughters, N.B.T., who is 11 years old, and G.R.S.C., who is 3 years old. We are very scared about COVID-19 and contracting it while we are detained here.

2. We have been detained by immigration since March 2, 2020. We arrived at Berks on March 11, 2020. COVID-19 has been known about and spreading for weeks. The staff still hasn't talked to us in detail about COVID-19.

3. Despite being detained here almost a month, I have only seen the Berks staff make changes this past week.

4. On Thursday, they posted one poster on the wall next to the phone, in English, Spanish and Creole about washing hands, and there is one poster in Spanish and English at the hallway about social distancing.

5. The other change that has happened this past week, is that there are now wipes next to the phones, so that whenever we are done using the phones, we have to wipe the phone.

6. But other things have not changed.

7. Inside the facility, no one wears gloves or masks. We never had any meeting with any of the staff explaining what the situation regarding COVID-19 is, we only learn what is going on from the TV news. On the TV there seems to be a lot of panic and concern, great steps being taken, but not here in the facility. I am so worried that we might get it inside because there are still around twenty people living here, not including the staff.

8. Two families left Berks on Monday afternoon, and three families left on Tuesday. There are now only five families in this facility.

9. Many people are still sick inside the facility. One of the families that are staying here with us, their child is severely sick and feverish. We are not well and we are scared.

10. Since I have been detained here, I have been experiencing episodes of panic attacks. Only after my attorney requested that I be given a doctor's appointment was I seen by a doctor and prescribed me some medication to be able to sleep.

11. My child is having a reaction to the shampoo that we are given. On April 1, the doctor finally gave my wife a small bottle of shampoo to use on my child.

12. We are not allowed to have our own hand sanitizer, gloves, or masks to protect ourselves.

13. On Wednesday, April 1, I was just coming back from the doctor's office when I saw a man filming me. I told him to please stop it and left the area. My wife was sitting with two other mothers when two people, one male and one female, came inside the room with their phones in their hands, videotaping them. My wife panicked and went inside her bedroom where our child was, but the man followed her inside her room. They did not ask us for permission to videotape us and we would not have given it. We are seeking asylum and our privacy matters. They do not need to film our faces to show conditions, or to use us for their videos. If they want to help us, they can do it without scaring us. They do not communicate with us about our safety.

14. All of the families here are devastated and scared because nobody would explain to us why suddenly they were allowing strangers take pictures and videos of us and our children. We are here to seek protection from our own government, and we do not know who will see these videos. Nobody knows what happens when these videos and pictures get on the internet.

15. Because of this, all the families refused to go to the dining room to eat for the whole day. But the camera man and woman came back the next day. Finally, after two days, one of the staff told us the camera has nothing to do with our immigration proceedings. But we are still scared about who could see these videos.

16. We are still all together in this one building. We are scared all of the time. No person in this facility speaks our language. We cannot communicate with anyone our fears, and they cannot talk to us either, just to make motions or sometimes find a person on the phone who can speak our language. We are not safe.

17. My family is here in the United States ready to receive my wife, myself and our children. I was granted a stay of deportation by a Court, so I cannot be deported. I ask that we be allowed to leave this detention center and be safe with our families.

This statement was prepared with me in my native language of Haitian Creole. I understood and agreed with the contents before signing. I also give my permission to have my signature electronically signed.

/s/ G.S.C.
_____

Date: April 5, 2020

EXHIBIT G

pennsylvania
DEPARTMENT OF HUMAN SERVICES

TO: County Children and Youth Agencies
Private Children and Youth Social Services Agencies
Child Welfare Service Providers

FROM: Jonathan Rubin
Deputy Secretary for Children, Youth and Families

RE: Guidance from the Department of Human Services, Office of Children Youth and Families regarding Coronavirus Disease 2019 (COVID-19)

DATE: March 11, 2020

In response to growing concerns about the spread of COVID-19 and its potential impact on the delivery of services to individuals and families the Department of Human Services, Office of Children, Youth, and Families (OCYF) has developed the following operational recommendations for counties and providers of child welfare services. Information will continue to be shared and disseminated going forward to address questions and concerns that have been brought to our attention.

Information will continue to be shared and disseminated going forward to address questions and concerns that have been brought to our attention. We continue to monitor information from the Pennsylvania Department of Health and the U.S. Centers for Disease Control and Prevention. Guidance developed by DHSwill be centrally located on this page, which will be updated as additional guidance becomes available. We encourage you to continue to consult these resources for updates on COVID-19, information on staying healthy, and updates on the situation in Pennsylvania.

Recommendations

Recommendation #1: Exercise and promote hygienic practices.

The best way to prevent illness is to avoid being exposed to COVID-19. Providers should remind staff that chances of exposure can be reduced by:

- Washing hands often with soap and water for at least 20 seconds especially after being in a public place, or after blowing noses, coughing, or sneezing.

- Using a hand sanitizer that contains at least 60% alcohol if soap and water is not readily available. People should cover all surfaces of hands and rub them

together until they feel dry.

- Avoiding touching eyes, nose, and mouth with unwashed hands.
- Covering mouths and noses with a tissue when coughing or sneezing or using the inside of their elbow.
- Cleaning AND disinfecting frequently touched surfaces daily. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- If sick, stay home.

Recommendation #2: Review your agency back-up plan and infection control procedures.

All counties and providers are strongly encouraged to:

- Review internal infection control protocols and emergency backup plans for events in which a provider does not have adequate staffing to meet individuals' health and safety needs.
- Evaluate staff adherence to provider infection control protocols.
- Evaluate capacity to implement emergency backup plans in the event staffing is impacted by the COVID-19 virus.

For questions or technical assistance related to emergency plans, counties and providers may contact the appropriate regional office.

OCYF Regional Office Contact Information

Central Regional Office Phone: 717-772-7702	**Northeast Regional Office** Phone: 570-963-4376
Southeast Regional Office Phone: 215-560-2249	**Western Regional Office** Phone: 412-565-5728

Recommendation #3: Report all suspected cases of COVID-19 to OCYF

For OCYF to be responsive to the needs related to COVID-19, timely information from the county and provider community is essential. Staff should follow Department of Health (DOH) guidance for evaluation, testing, and reporting related to staff or a beneficiary suspected of having COVID-19 available here. If staff or a person for whom

you provide services is suspected to have COVID-19 or tests presumptively positive for COVID-19, please notify the appropriate regional office.

Recommendation #4: Contact OCYF before making any changes to your business practice whenever possible.

It is strongly recommended that county child welfare agencies and providers contact OCYF before making any changes to their business practices in response to COVID-19. Examples of changes in business practices include, but are not limited to:

- Suspending services at a service location or temporarily closing programs.
- Reducing or eliminating the provision of placement for children or youth in a program.
- Closing county offices.

OCYF is monitoring the COVID-19 situation closely and is prepared to modify expectations for compliance on a case-by-case basis should emergency conditions present. By contacting OCYF, providers may be able to implement the most effective strategy for maintaining continuity of operations during COVID-19.

Providers may contact the appropriate regional office to notify OCYF of a proposed change in business practice and/or seek guidance related to a proposed change.

Recommendation #5: Document what actions were taken and maintain evidence for why actions were taken.

Counties and providers should document any changes to their operations and expenses incurred related to operations as a result of COVID-19 and maintain evidence to support why the changes were made. Doing so will help demonstrate the basis for an action in the event that the appropriateness of the action is questioned after COVID-19 is contained and operations return to normal. It will also support any changes that may need to be made and substantiate submitted claims for services rendered in an alternative manner due to COVID-19.

OCYF will provide technical assistance with the kind of evidence that should be maintained when counties or providers contact OCYF in accordance with Recommendation #4. In general, evidence that should be maintained includes, but is not limited to:

- **Orders or notices from local authorities**. Example: County Health Department *A* imposes a restriction on public gatherings of more than 20 people, forcing Provider *B* to close its vocational program for one week. Provider *B* should retain the official notice from County Health Department *A* as evidence to support the closure.

- **Correspondence and other records demonstrating inability to meet required staffing ratios or response times.** Example: Provider *A*'s employees are unable to report to work due to COVID-19-related reasons. Provider *A* attempts to secure temporary staff from three staffing agencies, but each agency reports that they too are experiencing staff shortages. As a result, Provider *A* is out of compliance with required staffing ratios. Provider *A* should retain copies of correspondence with each of the three staffing agencies to demonstrate that all possible efforts were made to secure enough staff.

Recommendation #6: Stay Informed

- COVID-19-specific information can be found at:
    - The Pennsylvania Department of Health's Coronavirus Update Page - https://www.health.pa.gov/topics/disease/Pages/Coronavirus.aspx
    - The Centers for Disease Control and Prevention's Coronavirus Page - https://www.cdc.gov/coronavirus/2019-ncov/

- The Pennsylvania Department of Health holds press briefings every day to announce the latest efforts and updates on the commonwealth's response to COVID-19. Counties and providers may watch a free live stream of the daily briefing at noon here: https://pacast.com/live/doh. An archive of past briefings is available here: https://pacast.com/video.

- One of the most important steps you can take to stay informed about our program is subscribe to our Listservs. Important announcements, including announcements about COVID-19, are regularly sent over the Listservs.
    - Please email ra-DPWOCYFNet@pa.gov requesting addition to the OCYF Listserv, if you are not already subscribed.

Resources for Infection Control Practices

- COVID-19 Information for at-risk Individuals: https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/Coronavirus%20At%20Risk%20Individuals.pdf

- Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF) (Source: CDC): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

- CMS Guidance for Home Health Agencies: https://www.cms.gov/files/document/qso-20-18-hha.pdf

pennsylvania
DEPARTMENT OF HUMAN SERVICES

- CMS Guidance on Respirators for Healthcare Personnel: https://www.cms.gov/files/document/qso-20-17-all.pdf

c: Natalie Bates
Jennie Pettet
Gloria Gilligan
Amanda Dorris
Charles Neff
Amber Kalp
Jacqulyn Maddon
Gabrielle Williams
Shelly Neptune

EXHIBIT H

pennsylvania
DEPARTMENT OF HUMAN SERVICES

TO: County Children and Youth Agencies
Private Children and Youth Social Services Agencies
Child Welfare Service Providers

FROM: Jonathan Rubin
Deputy Secretary for Children, Youth and Families

RE: Visitor, Meeting and Travel Guidance
During Coronavirus Disease 2019 (COVID-19)

ISSUED: March 26, 2020

EFFECTIVE: IMMEDIATELY

In response to growing concerns about the spread of COVID-19 and guidance issued by the Pennsylvania Department of Health, the Department of Human Services (DHS), Office of Children, Youth, and Families (OCYF) has developed the following recommendations for entities operating as a Child Residential and Day Treatment Facility licensed under Title 55 Chapter 3800.

Visitors

Residential Areas

1. It is recommended that all non-employee visitors be prohibited and alternative methods of communication (video conferencing, telephone calls) be utilized unless it is a medical necessity, required by court order, or necessary to ensure completion of duties for child welfare and juvenile probation agencies as outlined in the Child Protective Services Law regarding the safety and protection of a child.
    a. Exceptions should be provided for immediate family members. In addition to the exception for immediate family members, the above policy allows for visits by County Child Welfare or DHS staff, Behavioral Health Managed Care staff or Juvenile Probation Officers, if the following conditions are met:
        i. If the visit is deemed to be necessary, it is recommended that prior approval by the facility director be required;
        ii. Consideration should be given to designating a specific location for the visit where safe distance protocols can be met;
        iii. Each visit should be limited to the specific person of the intended visit.
        iv. It is recommended that visitors be screened using the guidance outlined in the "Long-Term Care Facility Visitation Guidance" provided by the Department of Health. The guidance can be found here;

v. If a person fails the screening, that person should be prohibited from remaining on campus;

vi. Have hand washing station(s) and/or hand sanitizer easily accessible to visitors;

vii. Consistently sanitize/clean visitation areas; especially high touch areas;

viii. Stagger visitations to limit the number of visitors in the facility at one time. No more than two visitors should be allowed at any one time regardless of the purpose.

ix. A questionnaire should be completed for each visit which includes the date, location, time in, time out, the person being visited, the person visiting and the person completing the screening;

x. If someone is turned away, providers should make every effort to conduct video conferencing visits. If video conferencing is not available, additional/daily phone contact should be allowed/considered;

xi. Provider agencies should ensure there is a designated family contact for questions/issues related to visitation; and

xii. Family members, counties and Behavioral Health Managed Care Organizations are to be notified of changes to a provider's visitation policy related to COVID 19.

2. All employee access should be restricted to work related activities only.

Campus

3. Vendors/Deliveries

    a. Should be limited when possible to specific non-residential locations, as deemed by the facility, and should minimize contact with people living and working at the facility.

        i. Daily screening using the guidance outlined in the "Long-Term Care Facility Visitation Guidance" provided by the Department of Health is recommended. The guidance can be found here.

        ii. A questionnaire should be completed for each delivery which includes the date, location, time in, time out, the person receiving the delivery, reason, and the person completing the screening.

        iii. If the person fails the screening, the person should be prohibited from remaining on campus and the physical delivery should be refused unless it is an essential item. If the item is deemed essential, appropriate safeguards including cleaning the surface of the item and hand washing with soap and water for a minimum of 20 seconds by anyone who touches the item should be used in the handling of the delivery.

4. Volunteers and Groups

    a. Are prohibited from visiting the campus.

Trainings/Meetings

On-Campus

1. All trainings and meetings should be held by phone or video conferencing.

Off Campus

1. All off campus training and meeting attendance should be prohibited.
    a. Telephone or other technology should be used as appropriate to take the place of face to face trainings and meetings.
    b. An exception can be made if the trip is deemed to be critically necessary and approved by the facility director.
        i. Each training/meeting should be limited to the minimum number of staff required.
        ii. A training/meeting form should be completed for each exception which includes the date, training/meeting attending, time departed, time returned, attendees, reason, location and person completing the form.
        iii. Individuals displaying signs of respiratory illness should be prohibited from in-person participation.

Trips

1. All trips including staff and residents from the facility should be restricted unless they are a medical necessity or ordered by a court
2. An exception will be made if the trip is deemed to be critically necessary and approved by the facility director.
        i. Each trip should be limited to the specific person and the minimum number of staff required.
        ii. A trip form should be completed for each trip which includes the date, time left, time returned, location, reason, attendees, and the person completing the form.
        iii. The trip form should also indicate if there was contact with anyone that was displaying signs of a respiratory illness.

With the Governor's authorization as conferred in the Proclamation of Disaster Emergency issued on March 6, 2020, all statutory and regulatory provisions that would impose an impediment to implementing this guidance are suspended. Those suspensions will remain in place while the proclamation of disaster emergency remains in effect.

Please direct any questions regarding this guidance to your Office of Children, Youth, and Families Regional Office. Additional COVID-19 related resources for providers is also available through the DHS website.

c: Natalie Bates, Chief of Staff, OCYF
Jennie Pettet, Director, OCYF Bureau of Children and Family Services
Gloria Gilligan, Director, OCYF Bureau of Budget and Fiscal Support
Amanda Dorris, Director, OCYF Bureau of Policy, Programs and Operations
Charles Neff, Director, OCYF Bureau of Juvenile Justice Services
Amber Kalp, Regional Director, Western OCYF
Jacqulyn Maddon, Regional Director, Northeast OCYF
Gabrielle Williams, Regional Director, Central OCYF
Shelly Neptune, Acting Regional Director, Southeast OCYF