

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master's of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.
2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.
3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.
4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of May 11, 2020, according to the World Health Organization (WHO), over 4,000,000 confirmed cases have been diagnosed in 215 countries or territories around the world and 278,993 deaths due to COVID-19 have been reported.¹ In the United States, which has the highest numbers of reported cases and deaths worldwide, 1,347,881 confirmed cases have been reported and 80,682 people have died as of May 11.² These numbers are likely to be an underestimate given the lack of

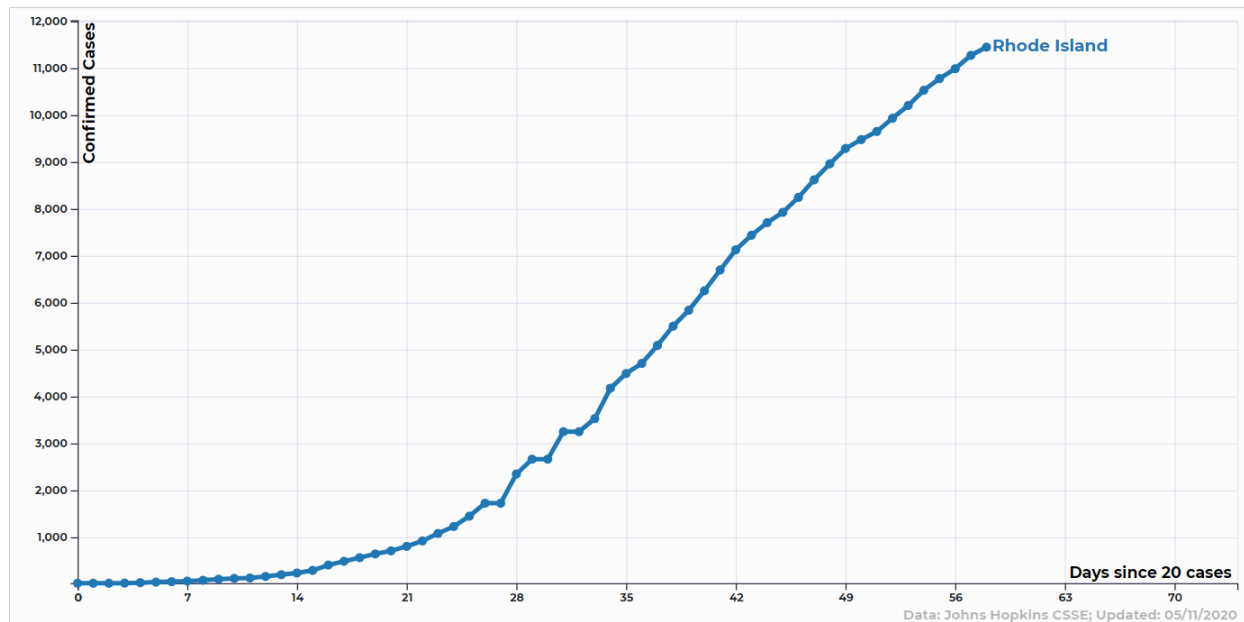
¹ See *WHO Coronavirus Disease (COVID-19) Dashboard*, WORLD HEALTH ORG., <https://covid19.who.int/> (last accessed May 11, 2020).

² See *Coronavirus COVID-19 Global Cases*, JOHNS HOPKINS UNIV., <https://coronavirus.jhu.edu/map.html> (last accessed May 10, 2020).

comprehensive testing.³

6. In the state of Rhode Island, as of May 11, 2020, there were 11,450 confirmed cases, 1,117 hospitalizations, and 430 deaths due to COVID-19 reported by the state Department of Health.⁴ As of May 4, 58% of COVID-19 hospitalizations had involved individuals 60 years of age or older, and an additional 31% of hospitalized cases involved individuals ages 40 to 59.⁵ Rhode Island ranks eighth highest among states in terms of the number of cases per 100,000 people—higher than Illinois, Washington state, or California.⁶ There continues to be cases of COVID-19 reported daily as indicated by the graph below which identifies confirmed cases for Rhode Island through May 11, 2020.⁷

Confirmed COVID-19 Cases by US States/Territories



7. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death for people at any risk spectrum. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill

³ Josh Katz, et al., *U.S. Coronavirus Death Toll Is Far Higher Than Reported, C.D.C. Data Suggests*, THE N.Y. TIMES (Apr. 28, 2020), <https://www.nytimes.com/interactive/2020/04/28/us/coronavirus-death-toll-total.html>.

⁴ *Rhode Island COVID-19 Response Data*, RHODE ISLAND DEP'T OF HEALTH (updated as of May 11, 2020 12:00 PM) <https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/>.

⁵ *Id.*

⁶ *Coronavirus in the U.S.: Latest Map and Case Count*, "Cases and deaths by state and county," THE N.Y. TIMES (updated May 11, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>.

⁷ *An interactive visualization of the exponential spread of COVID-19*, 91-DIVOC, <http://91-divoc.com/pages/covid-visualization/> (last accessed May 10, 2020).

COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections.

8. Those with serious cases of COVID-19 will likely require advanced support, including positive pressure ventilation and extracorporeal mechanical oxygenation in an intensive care setting. Those who survive serious cases of COVID-19 may require long-term rehabilitation because of damage to lung tissue and possibly other organs, including the heart, kidney, and neurologic systems.
9. The WHO identifies individuals at highest risk to include those over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.⁸ The WHO further states that the risk of severe disease from COVID-19 infection increases with age starting from around 40 years.⁹
10. The U.S. Centers for Disease Control and Prevention (CDC) identifies “older adults [age 65 and older] and people of any age who have serious underlying medical conditions” as at higher risk of severe disease and death.¹⁰ The CDC identifies such underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease (“including asthma or chronic obstructive pulmonary disease [chronic bronchitis or emphysema] or other chronic conditions associated with impaired lung function”), neurological and neurologic and neurodevelopmental conditions “[including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability...”], and current or recent pregnancy.¹¹ The CDC also identifies individuals with a body mass index (BMI) greater than 40 to be at higher risk for severe illness.¹² According to the CDC, hypertension has been associated with increased illness severity and outcomes.¹³ Hypertension is the most common of underlying condition, either alone or in combination with others, for people hospitalized for COVID-19.¹⁴

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

⁹ *Id.*

¹⁰ See *Groups at Higher Risk for Severe Illness*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 2, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html>.

¹¹ *Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission*, CENTERS FOR DISEASE CONTROL & PREVENTION (MAR. 12, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>.

¹² See *Groups at Higher Risk for Severe Illness*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 2, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html>.

¹³ *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 6, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

¹⁴ Shika Garg, et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID-NET, 14 States, March 1–30, 2020*. MMWR Morb Mortal Wkly Rep., CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 17, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

11. Data from U.S. COVID-19 cases published by the CDC on March 19, 2020, found a similar number of cases, and hospitalization, intensive care unit (ICU) admission, and case–fatality percentages, among individuals age 45–54 years and 55–64 years.¹⁵ The report concludes: “These preliminary data also demonstrate that severe illness leading to hospitalization, including ICU admission and death, can occur in adults of any age with COVID-19.”¹⁶

Understanding of COVID-19 Transmission

12. According to the CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.¹⁷ It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.¹⁸ New data examining the potential for air and surface contamination, conducted in a hospital setting, suggests that the transmission distance of COVID-19 may extend to 4 meters or about 13 feet.¹⁹ This same study found that half the samples taken from the soles of the shoes of hospital staff were positive for the SAR-CoV-2 virus.²⁰
13. People are thought to be most contagious when they are most symptomatic (the sickest), however, there is increasing evidence of asymptomatic²¹ and presymptomatic transmission. A recent report by the CDC of presymptomatic transmission in Singapore identified seven clusters of COVID-19 in which presymptomatic transmission likely occurred, accounting for 6.4% of locally acquired cases examined.²² These findings are similar to research in China which found that 12.6% of transmissions could have occurred before symptom onset in the source patient.²³

¹⁵ *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*, MMWR Morb Mortal Wkly Rep., CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

¹⁶ *Id.*

¹⁷ *How to Protect Yourself & Others*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 24, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>.

¹⁸ *How COVID-19 Spreads*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 13, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html>.

¹⁹ Zhen-Dong Guo, et al., *Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020*, DISPATCH, Vol. 26, No.7 (July 2020), https://wwwnc.cdc.gov/eid/article/26/7/20-0885_article.

²⁰ *Id.*

²¹ *How COVID-19 Spreads*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 13, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html>; see also Yan Bai, et al., *Presumed Asymptomatic Carrier Transmission of COVID-19*, JAMA 2020; 323(14): 1406-1407, <https://jamanetwork.com/journals/jama/fullarticle/2762028>; Zhang W., et al. *Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes*. EMERG MICROBES INFECT. 2020;9(1):386-389, <https://doi.org/10.1080/22221751.2020.1729071>.

²² See Wycliffe Wei et al., *Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 10, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e1.htm?s_cid=mm6914e1_w.

²³ See Zhanwei Du et al., *Serial Interval of COVID-19 among Publicly Reported Confirmed Cases*, 26 EMERGING INFECTIOUS DISEASES (2020), https://wwwnc.cdc.gov/eid/article/26/6/20-0357_article.

While the degree of asymptomatic transmission is still uncertain, a CDC Morbidity and Mortality Weekly Report (MMWR) stated that, “Because persons with asymptomatic and mild disease...are likely playing a role in transmission and spread of COVID-19 in the community, social distancing and everyday preventive behaviors are recommended for persons of all ages to slow the spread of the virus, protect the health care system from being overloaded, and protect older adults and persons of any age with serious underlying medical conditions.”²⁴ In some studies, up to half of individuals testing positive for the coronavirus reported no or mild symptoms.²⁵ Speech and other vocal activities such as singing have been shown to generate air particles which could transmit the virus responsible for COVID-19, with the rate of emission corresponding to voice loudness. News outlets have reported that during a choir practice in Washington on March 10, presymptomatic transmission likely played a role in SARS-CoV-2 transmission to approximately 40 of 60 choir members.²⁶

14. **The understanding of direct transmission as the most likely means of SARS-CoV-2 transmission, combined with evidence of asymptomatic and presymptomatic transmission suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.** Because of the risk of airborne spread, the CDC now recommends that everyone who is coming into contact with the air that others may breathe covers their face, though the CDC recognizes that a face covering is not a substitute for social distancing.²⁷
15. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. All 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.²⁸ Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. On March 9, Rhode Island

²⁴ *Coronavirus Disease 2019 in Children — United States, February 12–April 2, 2020*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 10, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e4.htm?s_cid=mm6914e4_w.

²⁵ Pien Huang, *What We Know About The Silent Spreaders Of COVID-19*, NATIONAL PUBLIC RADIO (Apr. 13, 2020), <https://www.npr.org/sections/goatsandsoda/2020/04/13/831883560/can-a-coronavirus-patient-who-isnt-showing-symptoms-infect-others>.

²⁶ See Richard Read, *A Choir Decided to Go Ahead With Rehearsal. Now Dozens Of Members Have COVID-19 and Two are Dead*, LA TIMES, <https://www.latimes.com/world-nation/story/2020-03-29/coronavirus-choir-outbreak> (Mar. 29, 2020).

²⁷ *How to Protect Yourself & Others*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 24, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>.

²⁸ *COVID-19*, ASSOC. OF STATE & TERRITORIAL HEALTH OFFICIALS, <https://www.astho.org/COVID-19/> (last accessed May 10, 2020).

Governor, Gina Raimondo, declared a state of emergency.²⁹ On March 28 Governor Raimondo buttressed that by closing all non-critical businesses and issuing a stay at home order to cover the entire state of Rhode Island.³⁰

16. These public health measures aim to “flatten the curve” of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.
17. In Spain, immigration authorities began gradually releasing people held in closed immigration detention centers (CIEs) on March 18.³¹ In Belgium, federal authorities released an estimated 300 migrants from detention on March 19 because detention conditions did not allow for safe social distancing.³² The UK government released 300 people from detention centers—about one third of its entire immigration detainee population—following legal action that argued that the government had failed to protect immigration detainees from the COVID-19 outbreak and failed to identify which detainees were at particular risk of serious harm or death if they do contract the virus due to their age or underlying health conditions.³³ As part of the legal action, Professor Richard Coker of the London School of Hygiene and Tropical Medicine stated that prisons and detention centers provide “ideal incubation conditions for the rapid spread of the coronavirus, and that about 60% of those in detention could be rapidly infected if the virus gets into detention centers.”³⁴
18. U.S. cities have experienced high levels of COVID-19 cases. As of May 10, the New York City metro region has seen more than 440,500 cases, Chicago has seen over 74,000 cases, Boston has seen nearly 59,000 cases (with total cases doubling every six weeks), Philadelphia has seen more than 47,000 cases, and the greater Seattle region has seen nearly 12,000 cases.³⁵ Over the past month Rhode Island has had about a

²⁹ *Executive Order: Declaration of Disaster Emergency*, STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS; GINA M. RAIMONDO, GOVERNOR (Mar. 9, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-02.pdf>.

³⁰ *Executive Order: Eleventh Supplemental Emergency Declaration – Staying at Home, Reducing Gatherings, Certain Retail Business Closures and Further Quarantine Provisions*, STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS; GINA M. RAIMONDO, GOVERNOR (Mar. 28, 2020), <https://governor.ri.gov/documents/orders/Executive-Order-20-13.pdf>

³¹ Europa Press, Madrid, *Interior abre la puerta a liberar a internos en los CIE por el coronavirus*, LA VANGUARDIA (Mar. 19, 2020, 7:54 PM), <https://www.lavanguardia.com/politica/20200319/474263064358/interior-abre-puerta-liberar-internos-cie.html>.

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

³³ Diane Taylor, *Home Office Releases 300 from Detention Centres amid Covid-19 Pandemic*, THE GUARDIAN (Mar. 21, 2020, 3:08 PM), <https://www.theguardian.com/uk-news/2020/mar/21/home-office-releases-300-from-detention-centres-amid-covid-19-pandemic>.

³⁴ *Id.*

³⁵ Josh Katz et al., *How Severe Are Coronavirus Outbreaks Across the U.S.? Look Up Any Metro Area*, THE N.Y. TIMES (updated May 11, 2020), <https://www.nytimes.com/interactive/2020/04/03/upshot/coronavirus-metro-area-tracker.html>.

2.5% daily increase in the number of confirmed cases, going from 1,727 confirmed cases on April 10, 2020 to 11,274 cases on May 10, 2020.³⁶ If it continues at a rate of 2.5% daily growth in the number of reported cases, by June 10, 2020 the number of confirmed cases in the state would be expected to over 24,000 cases. If the current restrictions on movement result in less social distancing, this number could be substantially higher.

19. Although the rate of newly confirmed cases appears to have slowed in certain states like Rhode Island, this does not indicate that the COVID-19 pandemic is anywhere near controlled. Under any scenario that the pandemic follows—assuming at least some level of ongoing mitigation measures—at least one study has confirmed that we must be prepared for at least another 18 to 24 months of significant COVID-19 activity, with hot spots popping up periodically in diverse geographic areas across the country.³⁷ Even if the pandemic wanes, it is likely that SARS-CoV-2 will continue to circulate in the human population and that second and third “waves” of increased transmission are likely, requiring swift implementation of social distancing, case identification, contact tracing and isolation. This may look like a seasonal pattern as past pandemic influenza viruses have done or it could be more erratic.³⁸ Of more immediate concern, the relaxation of public health measures in some parts of the country will inevitably lead to another surge of infection as more asymptomatic carriers are moving back within the community and possibly across county and state lines. In a leaked CDC/Health and Human Services document,³⁹ it is projected that new COVID-19 cases will surge to about 200,000 per day nationwide by June 1, accompanied by more than 3,000 deaths each day. The document predicts a sharp increase in both cases and deaths beginning about May 14, and an upward trajectory of both daily cases and deaths through June 1, where the projections end.⁴⁰
20. On May 4, a model from the Institute for Health Metrics and Evaluation (IHME) at the University of Washington updated their predictions for the number of deaths that may occur in the United States from 72,433 to 134,000 by early August—nearly double its previous prediction.⁴¹ IHME’s models have been relied on by the White House for its

³⁶ See *An interactive visualization of the exponential spread of COVID-19*, 91-DIVOC, <https://91-divoc.com/pages/covid-visualization/?chart=states&highlight=Rhode%20Island&show=all&trendline=default&y=fixed&scale=log&data=ases#states> (last accessed May 10, 2020).

³⁷ Kristine A. Moore, et al., *COVID-19: The CIDRAP Viewpoint: Part 1: The Future of the COVID-19 Pandemic: Lessons from Pandemic Influenza*, CENTER FOR INFECTIOUS DISEASE RESEARCH & POLICY, UNIV. OF MINNESOTA (Apr. 30, 2020), https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf.

³⁸ *Id.*

³⁹ COVID-19 HHS/FEMA Interagency VTC: Centers for Disease Control and Prevention Situation Update, CENTERS FOR DISEASE CONTROL AND PREVENTION (May 2, 2020), <https://int.nyt.com/data/documenthelper/6926-mayhhsbriefing/af7319f4a55fd0ce5dc9/optimized/full.pdf#page=1>.

⁴⁰ *Id.*

⁴¹ IHME, COVID-19 Estimation Updates: COVID-19: What’s New for May 4, 2020, http://www.healthdata.org/sites/default/files/files/Projects/COVID/Estimation_update_050420.pdf (last accessed May 11, 2020).

COVID-19 mortality predictions.⁴² As the IHME Director explained, the sharp increases are tied to relaxed social distancing and increased mobility in the United States.⁴³ It is therefore not only premature but unsafe to assume that precautions can be relaxed at this stage of the pandemic.

Risk of COVID-19 in Immigration Detention Facilities

21. The conditions in immigration detention facilities do not allow detained individuals or staff to protect themselves and therefore are likely to facilitate the spread of COVID-19.
22. Immigration detention facilities are enclosed environments. These kinds of enclosed environments, like cruise ships and nursing homes, have seen higher rates of COVID-19 infection than the general population. Immigration detention facilities have even greater risk of COVID-19 transmission than other enclosed environments because of crowding within the facility, and limited access to hygiene, and structural limitations. People in immigration detention are housed in crowded spaces of limited size and are subjected to security measures that force them into close contact with guards. They cannot practice the “social distancing” necessary to effectively prevent the spread of COVID-19. Bathrooms facilities—toilets, showers, and sinks—and other common areas are shared, without adequate surface disinfection between users. Food preparation and distribution without proper precautions also presents a further site for the virus to spread. Infectious spread presents a particular challenge in these facilities where the population often is disproportionately vulnerable, while facilities provide limited medical care.⁴⁴
23. The CDC guidance on correctional and detention facilities, posted March 23, 2020, refers to social distancing as a “cornerstone of reducing transmission of respiratory diseases such as COVID-19.”⁴⁵ The guidance specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons “ideally 6 feet between all individuals, regardless of the presence of symptoms” including: increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.⁴⁶

⁴² Reuters, *New Projection Puts U.S. COVID-19 Deaths at Nearly 135,000 by August*, THE N.Y. TIMES (May 4, 2020), <https://www.nytimes.com/reuters/2020/05/04/us/04reuters-health-coronavirus-usa-projections.html>.

⁴³ Eric Levenson, et al., *Coronavirus Model Projects 134,000 Deaths in US, Nearly Double Its Last Estimate*, CNN (May 4, 2020), <https://www.cnn.com/2020/05/04/health/us-coronavirus-monday/index.html>.

⁴⁴ *Public Health*, PRISON POLICY INITIATIVE, <https://www.prisonpolicy.org/health.html> (last accessed May 11, 2020)

⁴⁵ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Mar. 23, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html> (last accessed May 11, 2020).

⁴⁶ *Id.*

24. The CDC guidance also describes necessary disinfection procedures including to thoroughly clean and disinfect all areas where a confirmed or suspected COVID-19 case spent time.⁴⁷
25. A paper posted online in late April in advance of publication in the *Journal of Urban Health* modeled the rate of COVID-19 transmission within 111 ICE detention facilities and found high rates of transmission even under the most optimistic assumptions of coronavirus transmission dynamics.⁴⁸ In the model presented by the authors, who include epidemiologists and physicians with experience working in correctional settings, 72% of people detained in ICE facilities would be infected with COVID-19 90 days after a facility had five infected cases.⁴⁹ The results of the model, which assume ineffective social distancing measures have been implemented in ICE facilities, are borne out by recent evidence from prisons that have put in place aggressive testing programs. For example, in Marion County, Ohio, over 80% of prisoners have tested positive⁵⁰; in Lincoln County, Arkansas, 40% of inmates have tested positive⁵¹; nearly 60% of inmates at Neuse Correctional Institution in North Carolina have tested positive⁵²; 52% in Harris County, Texas⁵³; and 56% of inmates at Lakeland Correctional Facility in Michigan.⁵⁴
26. As I elaborate below, the protocols adopted by ICE nationally and at the Donald W. Wyatt Detention Facility (Wyatt) are inadequate to prevent or manage the spread of COVID-19.

Existing Protocols Will Not Prevent Introduction of COVID-19 at Wyatt

27. I have reviewed ICE guidance on its website on COVID-19, updated on May 8, 2020,⁵⁵ and the following documents:

⁴⁷ *Id.*

⁴⁸ Michael Irvine et al., *Modeling COVID-19 and Impacts on U.S. Immigration and Customs Enforcement (ICE) Detention Facilities*, 2020, *Journal of Urban Health* 2020, https://whistleblower.org/wp-content/uploads/2020/04/Irvine_JUH_ICE_COVID19_model.pdf (last accessed May 11, 2020).

⁴⁹ *Id.*

⁵⁰ Sarah Volpenhein, *Marion Prison Coronavirus Outbreak Seeping Into Larger Community*, MARION STAR (Apr. 25, 2020), <https://www.marionstar.com/story/news/local/2020/04/25/marion-prison-ohio-coronavirus-outbreak-seeping-into-larger-community/3026133001/>.

⁵¹ Cary Aspinwall and Joseph Neff, *These Prisons Are Doing Mass Testing For COVID-19—And Finding Mass Infections*, THE MARSHALL PROJECT (Apr. 24, 2020), <https://www.themarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections>.

⁵² Ames Alexander, *'It's Ground Zero.' How Fear Gripped An NC Prison As COVID-19 Infected Hundreds.*, THE CHARLOTTE OBSERVER (updated Apr. 28, 2020), <https://www.charlotteobserver.com/news/coronavirus/article242109076.html>.

⁵³ St. John Barned-Smith, *After Widespread Testing, Harris County Sheriff Reports COVID-19 Spike At Jail*, HOUSTON CHRONICLE (Apr. 27, 2020), <https://www.houstonchronicle.com/news/houston-texas/houston/article/After-widespread-testing-Harris-County-sheriff-15229961.php>.

⁵⁴ Emma Nicolas, *A Michigan Prison Tested All Its Inmates for COVID-19. More Than Half Have the Virus.*, WZZM 13 (Apr. 27, 2020), <https://www.wzzm13.com/article/news/health/coronavirus/more-than-half-lakeland-prisoners-test-positive-for-coronavirus/69-d6aee1cd-7935-4933-857c-5ebd92c3dd3d>.

⁵⁵ *ICE Guidance on COVID-19*, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, <https://www.ice.gov/coronavirus> (last updated May 8, 2020).

- a) ICE’s protocol for a clinical response to COVID-19 (“Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)” version 6.0 issued March 6, 2020), attached as exhibit B.
- b) The March 27, 2020 Memo entitled “Memorandum on Coronavirus Disease (COVID-19) Action Plan, Revision 1” (“ICE Action Plan”), from Enrique M. Lucero, Executive Associate Director, Enforcement and Removal Operations, addressed to Detention Wardens and Superintendents, attached as Exhibit C.
- c) The April 4, 2020 guidance from ICE Enforcement and Removal Operations (April 4 Memo), attached as Exhibit D.
- d) The April 10, 2020 ICE ERO COVID-19 Pandemic Response Requirements guidance (April 10 Guidance), attached as Exhibit E.
- e) In re: Donald W. Wyatt Detention Facility, 20-mc-00004, STATUS REPORT (May 11, 2020) (May 11 Status Report), attached as Exhibit F.
- f) Supplemental Declaration of Daniel W. Martin (Apr. 17, 2020), *Medeiros v. Martin*, No. 20-cv-00178-WES (D.R.I. Apr. 19, 2020), Doc. 12-1, attached as Exhibit G.
- g) The declarations of Petitioners Gagik Mkrtchian and Oscar Yanes.

28. Based on my training and decades of professional experience in public health, the procedures described therein are insufficiently clear on several key points and are likely to be inadequate to prevent or mitigate the rapid transmission of COVID-19 in the Wyatt facility. Nearly every measure Wyatt identifies in the May 11 Status Report as a part of their strategic response is qualified. For example, in paragraph 2, Wyatt’s communications with agencies sending detainees is intended to “minimize” transfer of symptomatic patients (8b); incoming symptomatic detainees are isolated “as much as possible” (8e); staff are encouraged to minimize their community exposures (8j) and physical contact with one another (8k).

29. The protocols do not sufficiently implement the preventative measures outlined below. The documents also do not include **the identification of special protections for medically high-risk patients.**

30. **Social distancing:** Although ICE recognizes that social distancing is an important preventive measure, its guidance remains inadequate insofar as it fails to make clear that social distancing is required rather than just recommended, to adequately mitigate the spread of COVID-19. Thus, the measures are merely aspirational and therefore insufficient. Likewise, Wyatt’s guidance remains inadequate insofar as it fails to make clear that social distancing is required—rather than just recommended—to adequately mitigate the spread of COVID-19.

- a) The “ICE Action Plan” states that “Wardens and Facility Administrators

should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice.” ICE’s April 10 Guidance states that facilities should stagger detainee access to activities like recreation, law library and meals to limit the number of interactions between detainees from other housing units. While ICE is correct to emphasize maximizing social distancing, however these suggested steps fall short of what is necessary to prevent transmission if SARS-CoV-2 is introduced and say nothing about crowding in housing units.

- b) On its website, ICE states that it is taking measures to reduce the population of the prisons to 70 percent. ICE’s April 10 Guidance is inconsistent and says that efforts should be made to reduce the population to 75 percent capacity. In either case, the number is arbitrary as ICE provides no indication that there is a basis to believe that social distancing within dormitories and cells will be possible when the facilities are operating at 70 percent of capacity or lower, especially given physical constraints of the facility’s layout and restrictions on individuals’ movements. Nor is there any indication that social distancing will be possible where bathrooms and other facilities (like waiting rooms for medical clinics and court) are shared by many individuals if the facilities are at 70 or 75 percent capacity. Further, detention facilities may have an overall capacity below a certain level (e.g., 50%) but due to the need to house individuals by gender and risk category and the limitations of the structure of housing, individual units or pods may have housing levels much higher than the average.
- c) ICE’s April 10 guidance recognizes “that strict social distancing may not be possible” given crowding in facilities and physical infrastructure, and couches guidance in terms of feasibility instead of as a mandatory directive (for example, directing to rearrange beds, only “[i]f practicable” and to maintain a distance of six feet from one another “[w]henver possible”). Because social distancing is the primary means of preventing transmission of the virus, ICE’s failure to create a plan that meaningfully implements social distancing renders the plan ineffective.
- d) It is difficult to assess the extent to which Wyatt is effectively implementing social distancing guidance consistent with CDC recommendations. For example, in the strategies mentioned in the portion of Wyatt’s May 11 Status Report concerning social distancing (¶ 8), the declaration states that the Facility is “[d]irecting detainees to socially distance themselves, by, among other things, sitting one to two detainees at a four-person table during any non-lockdown mealtimes, providing guidance to avoid congregating in groups, permitting detainees to access the recreation yard attached to their unit on non-lockdown times, and reassigning detainees to available cells so as to further increase social distancing within the cells.” None of these

directions or provision of guidance ensure compliance with the CDC's recommendation to maintain, at all times, a minimum radius of six feet in physical distance from other individuals. Wyatt provides no indication that these directions are being followed or that there is a basis to believe that sitting two people at a four person table allows for adequate social distancing, or that social distancing within dormitories and cells is possible when the facilities are operating at 73 percent of capacity. Nor is there any indication that social distancing will be possible where bathrooms are shared by many individuals if the facilities are at 73 percent capacity. Furthermore, no Petitioners reported being directed to sit only one to two at a table, or to distance themselves while waiting in line for meals or to make phone calls.

31. **Review of High-Risk Individuals:** ICE's April 10 Guidance directs local jails housing ICE detainees to identify any detainee who meets the CDC's identified criteria for populations being at higher-risk for serious illness from COVID-19. ICE's April 10 Guidance is inconsistent with the guidance given by ERO just days earlier, and they both actually fail to adhere to CDC guidelines.

- a) For instance, this new guidance fails to identify pregnant or post-partum women and people with histories of smoking. The previous guidelines earlier failed to identify smoking history or body mass index over 40 as risk factors, both of which are included by the CDC. In an April 8 CDC MMWR, obesity (BMI \geq 30) was second only to hypertension among the most commonly reported underlying medical conditions among individuals hospitalized due to COVID-19, with 48.3 percent of patients.⁵⁶
- b) Criteria for high-risk factors are not comprehensive and are constantly evolving based on new studies and data. For instance, data from U.S. COVID-19 cases published by the CDC found a similar number of cases, and hospitalization, intensive care unit (ICU) admission, and case-fatality percentages, among individuals age 45-54 years and 55-64 years,⁵⁷ suggesting that ICE's cut-off age of 60 (in the prior guidance) and 65 (in the newest document) are both insufficient.
- c) ICE's April 10 Guidance does not identify the steps they are taking to protect these high-risk patients from contracting COVID-19. The guidance merely notes that ICE must identify these individuals, their medical issues, and location. There is nothing that mandates their release or requires any other protective measures. If, for example, they are cohorted— as I explain below — that measure will facilitate rather than prevent the spread of COVID-19 in the absence of adequate social distancing and sanitation measures. Because

⁵⁶ See Shikha Garg et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Apr. 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w#T1_down.

⁵⁷ *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*, MMWR Morb Mortal Wkly Rep., CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

the ICE guidance fails to create increased protections for people with risk factors for serious illness and death from COVID-19, they are unlikely to detect illness in these patients until many of them have already been exposed to and contracted the coronavirus and fallen critically ill.

- d) ICE also does not appear to be following its own guidance at Wyatt. Moreover, Wyatt does not appear to be following either ICE's guidance or the CDC's criteria. Wyatt does not report any measures taken to identify medically high-risk individuals, or any steps taken to protect such individuals from contracting COVID-19. No Petitioners reported ICE identifying high-risk individuals, or taking protective measures regarding potentially infected individuals, let alone isolating them in a separate room. Because Wyatt fails to create increased protections for people with risk factors for serious illness and death from COVID-19, the Facility is unlikely to detect illness in these individuals until many of them have already been exposed to and contracted the coronavirus and fallen critically ill.

32. **Screening Measures and Quarantine:** ICE's protocols do not address how the facilities will account for the large number of people who may have potentially already been exposed to COVID-19. This includes not only new detainees, but also staff, vendors and other individuals who go in and out of detention facilities. Screening measures will not be sufficient to identify infected individuals who come into ICE facilities because of presymptomatic transmission and community spread, which make temperature checks and questions about past contacts insufficient. Facilities would also need increased physical space to isolate those who may be infected upon entry.

- a) The ICE Action Plan states that "enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities with 'sustained community transmission'" as determined by the CDC. The entire state of Rhode Island is listed as having "widespread" community transmission,⁵⁸ requiring enhanced screening. The May 11 Status Report states that, already, there are 15 positive COVID-19 test among detainees, and 6 positive tests among staff at Wyatt. The enhanced screening is identified as verbal screening related to potential exposure and risks and temperature checks. However, we know that this is insufficient due to both asymptomatic and presymptomatic transmission.
- b) ICE's April 10 Guidance states that asymptomatic people with suspected COVID-19 contact or those who meet epidemiological risk criteria will be quarantined and monitored for 14 days with symptom checks. The protocol is written as if this is a rare occurrence, reflecting smaller outbreak management, but the prevalence of COVID-19 is now growing to such an extent that a large share of newly arrived people may have recent contact

⁵⁸ *Cases in the U.S.*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last updated May 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html.

with someone who is infected, or will have been in areas of community spread. ICE would therefore need to use this level of individual monitoring for every person arriving in detention. Accordingly, ICE would need to dramatically expand its medical facilities and staffing to conduct this daily monitoring of every newly arrived person for 14 days. ICE has not indicated that it has the capacity to meet this demand.

- c) Under ICE's April 10 Guidance, ICE would also need to isolate these individuals, as movement of presymptomatic and asymptomatic individuals in the general population of any housing configuration short of single-celling could facilitate transmission. ICE does not suggest it is taking these measures, instead calling for intakes in cohorts where transmission between intakes may occur. It does not appear that ICE has the physical infrastructure in which to isolate these individuals. As I discussed below, the CDC guidance recommends *individual* quarantine and isolation as best practices. The practice of cohorting—grouping similarly-situated individuals—is not preferred because it results in potentially asymptomatic carriers mixing in even closer quarters with those who are not yet sick.
- d) Given presymptomatic and asymptomatic transmission, to effectively screen staff, the facilities would have to conduct frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities, 92.1% of cities reported that they do not have an adequate supply of test kits.⁵⁹ The availability of tests remains limited, and Rhode Island reports having tested far fewer individuals than all of its neighboring states.⁶⁰ Given the shortage of COVID-19 testing in the United States, it is likely that detention facilities will continue to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19.
- e) Wyatt's May 11 Status Report states that all new detainees are subject to a 16-day quarantine period in a single person cell, isolated from all other detainees. While quarantine is appropriate, it depends upon having enough space to continue to maintain new detainees in individual quarantine.
- f) Notably missing from questions around symptoms are questions about recent loss of smell or taste, which has been frequently associated with COVID-19. The staff and visitor screening form is even more limited in terms of the questions that are asked, despite the fact that staff and visitors may pose the greatest threat of introduction of COVID-19 into the facility given their

⁵⁹ *Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation's Mayors*, THE UNITED STATES CONFERENCE OF MAYORS (Mar. 27, 2020), <https://www.usmayors.org/issues/covid-19/equipment-survey/>.

⁶⁰ Sharon Begley, *Many states are far short of Covid-19 testing levels needed for safe reopening, new analysis shows*, STAT NEWS (Apr. 27, 2020), <https://www.statnews.com/2020/04/27/coronavirus-many-states-short-of-testing-levels-needed-for-safe-reopening/>.

frequent contact with the community and with detainees. Also notable is that screening only asks about contact with confirmed COVID-19 cases. Given the limited availability of testing, this is insufficient to identifying potential close contacts to suspected COVID-19 cases. Both detainees and staff/visitors should be asked all of the following questions:

- Have you experienced any symptoms of COVID-19 (fever, shortness of breath, sore throat, cough, temperature, loss of smell, loss of taste, myalgia, fatigue, nausea, diarrhea) since your last screening?
- Have you had any close contact with anyone diagnosed with COVID-19?
- Have you had any close contact with anyone displaying symptoms of COVID-19 (shortness of breath, cough, temperature, loss of smell, loss of taste, fatigue, sore throat, myalgia, nausea, and diarrhea)?
- Have you been in close contact with anyone who has been told to self-quarantine themselves?

- g) Following 16 days of quarantine, Wyatt states that new detainees are “medically screened for COVID-19 related symptoms,” and if they are cleared, they are assigned to another unit in the general population. However, given confirmed cases among guards, and that we know that verbal screening and temperature checks, as provided for in Screening Protocols, are insufficient due to both asymptomatic and pre-symptomatic transmission, there remains a possibility of transmission to new detainees and to the general population without implementing testing.
- h) In the event of a confirmed case, the report states that the facility will “[s]ecure and isolate” the detainees’ unit. It is important to be clear that the use of “isolate” here is not that of medical isolation and more akin to quarantine. The report does not differentiate individuals in the unit who are identified as close contacts from those who are not close contacts. It is unclear why contact tracing is conducted if there is no plan for removing close contacts from others within the unit. By mixing close contacts with others, the potential for transmission increases. Individuals identified as close contacts should be removed from the unit and quarantined separately.
- i) The May 11 Status Report has a section on “Protocols in the event of a confirmed COVID-19 case” but does not identify a protocol for a suspected COVID-19 case. The same process identified for a confirmed case should be initiated for a suspected case, including medical isolation, contact tracing, disinfection, etc. It is unclear if such steps are envisioned or if action will only be taken after a case has tested positive, at which stage infection will have likely spread to potentially numerous close contacts.
- j) Wyatt states that staff who experience COVID-19 related symptoms are

expected to self-report their symptoms and will be prohibited from working. However, given pre-symptomatic and asymptomatic transmission, to effectively screen staff, the facilities would have to conduct frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. Given the shortage of COVID-19 testing in the United States—and that no Petitioners report detainees in their unit being tested for COVID-19 despite multiple positive tests among staff and detainees—it does not seem likely that Wyatt will conduct aggressive, widespread testing needed to identify all positive cases of COVID-19.

33. **Testing:** ICE’s guidance also fails to provide clear metrics for when to test individuals. The April 10 guidance does not address the lack of adequate testing in facilities. While the guidelines for testing may evolve over time, the protocol should create a structure for daily dissemination of testing criteria from ICE leadership, and time for daily briefings among all health staff at the start of every shift, to review this and other elements of the COVID-19 response.
- a) The lack of metrics for staff and clinicians further limits the efficacy of the isolation procedures discussed more fully below. To the extent that ICE is not providing clear guidance or sufficient resources to test for COVID-19, it will not be able to identify “confirmed cases.” Wyatt also fails to provide clear metrics for when to test individuals. Yet much of both ICE’s and Wyatt’s guidance on when to isolate individuals relies upon identifying these confirmed cases. Even were institutions have capacity for isolation of confirmed cases and safe cohorting of close contacts, if the facilities are not identifying who is a confirmed case, they will not be able to trigger the necessary precautions to prevent transmission from this case. I address more fully the limitations on infrastructure in isolation and cohorting more fully below.
 - b) ICE’s website states that it will test individuals in compliance with CDC guidelines. However, CDC guidance specifically identifies “[r]esidents in long-term care facilities or other congregate living settings, including prisons and shelters, with symptoms” as “high priority” for testing, of greater priority than persons with symptoms of COVID-19 in the community or individuals prioritized by health departments for public health monitoring or other reasons.⁶¹ Yet multiple declarations of detainees at Wyatt reported no testing was provided even when an individual displayed symptoms. None of the ICE guidance or Wyatt’s plan provides any indication that ICE or Wyatt is training its clinicians based on these guidelines. Wyatt only states that it will test individuals who present symptoms consistent with COVID-19. As a result, ICE is unlikely to detect illness in these patients until many of them are critically ill.

34. **Staffing:** ICE’s protocols fail to include guidance for health staff or administrators

⁶¹ *Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html> (last accessed May 11, 2020).

regarding how to plan their surge capacity needs as the level of medical encounters increases and the number of available staff decreases, due to illness.

- a) The ICE memo states that facilities are “expected to be appropriately staffed” but it provides with no further criteria for what will be appropriate as needs increase. Similarly, ICE’s April 10 guidance states only that facilities should determine “minimal levels of staff.” Nor is there guidance as to the qualifications of staff, particularly in the medical unit.
- b) This is of particular concern as Wyatt is located in Central Falls, Rhode Island, which currently has the highest number of cases of people who have tested positive for COVID-19 per 100,000 people in the state.⁶² Planning to meet the surge of needs is a critical component of the CDC guidance on long term care response and is a critical omission in this protocol.
- c) As clinical staff have no experience with this disease, ICE should develop rational clinical criteria for transfer to an acute care hospital. As with the lack of guidance on testing, this lack of clear guidance on how to determine who meets criteria for hospital transfer may prove deadly for detained people.

35. **Isolation:** The CDC recommends medical isolation of confirmed or suspected cases. A range of strategies are presented for isolation depending upon the infrastructure of the facility, however what is recommended as the most effective approach is confining confirmed and suspected cases individually “to a single cell with solid walls and a solid door that closes” to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space.⁶³

- a) ICE’s protocol for isolation states: “ICE places detainees with fever and/or respiratory symptoms in a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents, such as COVID-19.” These procedures would be sufficient to address a limited number of infected individuals. However, many facilities only have 1-4 of these medical rooms available in the facility. Given the rate of spread in detention facilities, there will be many more than 1-4 people with COVID-19 in the detention centers. This limited physical infrastructure will mean that ICE cannot comply with this protocol. ICE fails to provide a plan for how it will isolate symptomatic or exposed individuals when the number of these individuals exceeds the number of these medical isolation rooms. As

⁶² *Rhode Island COVID-19 Response Data*, RHODE ISLAND DEP’T OF HEALTH (dated as of May 11, 2020 12:00 PM) <https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/>.

⁶³ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Mar. 23, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html> (last accessed May 11, 2020).

discussed above, ICE also fails to address how it will staff facilities when there are many individuals in isolation and quarantine.

- b) ICE’s April 10 guidance seems to recognize that it does not have the capacity at many facilities to isolate even confirmed cases, let alone preventing transmission among pre-symptomatic and asymptomatic close contacts to these confirmed cases. ICE’s guidance states that ICE be notified when confirmed cases exceeds number of individual isolation spaces available so that transfer to other facilities, hospitals, or release can be coordinated. This plan is likely already a non-viable alternative as COVID-19 cases spread throughout the country. To date, ICE has reported infections at facilities in California, Arizona, Texas, New Mexico, Colorado, Louisiana, Pennsylvania, New York, New Jersey, Florida, Georgia, Mississippi, Illinois, Michigan, Virginia, Alabama, Ohio, Massachusetts, and Rhode Island.⁶⁴ Transfer also risks spread of infection. As discussed above, ICE provides no indication that it has the space to safely cohort during the potential incubation period, and transfer during this period to open up space in one facility could facilitate transmission to another.
- c) Wyatt’s protocol for isolation states that if a detainee tests positive for COVID-19, Wyatt will “[i]solate the detainee in the medical isolation/negative pressure unit.” The May 11 Status Report states that a total of 160 beds are available in a negative pressure environment, however Wyatt states that some of these beds are already designated to quarantine new detainees. It is therefore not clear how many beds are available for isolation specifically, given ongoing needs for quarantining new detainees as well as close contacts of suspected and confirmed cases. As discussed above, Wyatt also fails to address how it will staff facilities when there are many individuals in isolation and quarantine.

36. Cohorting: ICE’s guidance recognizes limited capacity for isolation and outlines cohorting procedures that risk exposing many individuals to the virus.

- a) Individuals in close contact of a confirmed or suspected COVID-19 case—defined by the CDC as having been within approximately 6 feet of the individual for a prolonged period of time or having had direct contact with secretions of a COVID-19 case (e.g., having been coughed on)—should be quarantined for a period of 14 days. The same precautions should be taken for housing someone in quarantine as for someone who is a confirmed or suspected COVID-19 case put in isolation—ideally placement in a single cell with solid walls and a solid door.⁶⁵

⁶⁴ *ICE Guidance on COVID-19*, U.S. IMMIGRATION AND CUSTOMS ENF’T, <https://www.ice.gov/coronavirus> (last updated May 11, 2020).

⁶⁵ *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html> (last accessed May 11, 2020).

- b) The CDC guidance recognizes that housing detainees in isolation and quarantine individually, while “preferred,” may not be feasible in all county jail settings and discusses the practice of “cohorting” when individual space is limited. The term “cohorting” refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a particular case together as a group. The guidance states specifically that “Cohorting should only be practiced if there are no other available options” and exhorts correctional officials: “**Do not cohort confirmed cases with suspected cases or case contacts.**” [emphasis in original]. Individuals who are close contacts of different cases should also not be kept together.
- c) Where individual rooms are not available, the CDC guidance describes a hierarchy of next best options for cohorting, which in order from lesser risk to greater risk includes housing individuals under medical isolation: 1) in a large, well-ventilated cell with solid walls and a solid door that closes fully; 2) in a large, well-ventilated cell with solid walls but without a solid door; 3) in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells; 4) in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells.⁶⁶
- d) The CDC guidance also says that detention facilities should “Ensure that cohorted cases wear face masks at all times.”⁶⁷ This is critical because not all close contacts may be infected and those not infected must be protected from those who are if individuals are cohorted. However, face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it; and replacing the mask with a new one if it becomes damp (e.g., from sneezing) and not to re-use single-use masks. There are times when detainees will necessarily not be able to wear masks, if available. For example, during meals. In these instances, detainees should eat individually or with proper distancing from others.
- e) With regards to single-use of masks, it’s important to note that face masks are in short supply. In a joint letter to President Trump, the American Medical Association, the American Hospital Association, and the American Nurses Association called on the administration to “immediately use the Defense Production Act to increase the domestic production of medical supplies and equipment that hospitals, health, health systems, physicians, nurses and all

⁶⁶ *Id.*

⁶⁷ *Id.*

front line providers so desperately need.”⁶⁸ In a survey United States cities, 91.5% of the cities reported that they do not have an adequate supply of face masks for their first responders and medical personnel.⁶⁹ There are also widespread shortages of personal protective equipment—particularly N-95 masks—sufficient to provide even for health care workers, in our nation’s hospitals, let alone medical providers and other individuals coming into contact with the virus in county jails.⁷⁰ Many public health leaders are calling for masks to be reserved for health care staff, who face increased risk and are vitally needed to sustain emergency care. Hospitals in the New York City area, unable to access masks locally, are reportedly turning to a private distributor to airlift millions of protective masks out of China.⁷¹

- f) While ICE’s April 10 Guidance recognizes that confirmed cases should not be confined with suspected cases or close contacts, it does not provide guidance as to how social distancing will occur within cohorts of suspected cases or close contacts. The guidance further states that individuals should always wear a face mask when “outside of the isolation space, and whenever another individual enters the isolation room.” However, “cohorting” of suspected cases and of all contacts without masks means that individuals (in either group) who are not infected may be forced into close proximity with others in the cohort who are exposed. Cohorting in this way could mean disease transmission will be facilitated rather than prevented. In large cohorts, this will mean transmission to many individuals. This practice goes against the CDC guidance.
- g) Based on the May 11 Status Report, Wyatt appears to be using the same unit to quarantine new detainees as to isolate confirmed cases. Wyatt is also not testing individuals housed in dormitories after a suspected positive test case was removed to determine whether others in the dormitory are infected.

37. **Sanitization:** ICE’s April 10 Guidance fails to include important aspects of CDC’s guidelines on cleaning and disinfection. It also fails to establish what personal protective equipment (PPE) must be worn by staff or detainees while they are cleaning these areas.

⁶⁸ *AHA, AMA and ANA Letter to the President to Use DPA for Medical Supplies and Equipment*, AM. HOSP. ASS’N (Mar. 21, 2020), <https://www.aha.org/lettercomment/2020-03-21-aha-ama-and-ana-letter-president-use-dpa-medical-supplies-and-equipment>.

⁶⁹ *Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation’s Mayors*, THE UNITED STATES CONFERENCE OF MAYORS (Mar. 27, 2020), <https://www.usmayors.org/issues/covid-19/equipment-survey/>.

⁷⁰ Michael T. Osterholm & Mark Olshaker, *Opinion, It’s Too Late to Avoid Disaster, but There Are Still Things We Can Do*, N.Y. TIMES (Mar. 27, 2020), <https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html>.

⁷¹ Christina Jewett & Lauren Weber, *Hospital Suppliers Take to the Skies to Combat Dire Shortages of COVID-19 Gear*, LANCASTER ONLINE (Mar. 26, 2020), https://lanasteronline.com/news/health/hospital-suppliers-take-to-the-skies-to-combat-dire-shortages/article_0830ffb0-6f89-11ea-89ed-bbd859186614.html.

- a) Even where ICE has stated that it is addressing this source of infection, discrepancies between the stated policies and the declarations of detainees at Wyatt provide a basis for concerns that ideal response plans are not being implemented: For example, while ICE states that soap dispensers and paper towels are “routinely checked and available for use”, and that “liquid soap, running water... disposable paper towels, and no touch receptacles” are available, individuals at Wyatt report running out of soap, cleaning products, and paper towels (Declarations of Mkrtchian and Yanes).
 - b) ICE also states in its April 10 guidance that hand sanitizer will be provided where permissible, but Mr. Yanes reports that hand sanitizer is not available.
 - c) Detainees report that they were responsible for cleaning common areas, like bathrooms, dining spaces, and sleeping cells, but are not using proper disinfectant, not cleaning between usage, and generally failing to properly clean as they are not trained to do so (Declarations of Mkrtchian and Yanes).
38. **PPE:** As discussed above, the CDC recognizes that masks are not a substitute for social distancing. Therefore, even when masks are worn, it is still important for facilities to practice social distancing. This is especially true where the masks are only cloth masks, not the medical grade N-95 masks that are being used in hospitals to prevent spread of COVID-19 between workers who come into close contact with the virus.
- a) ICE’s April 10 guidance recognizes that N-95 masks may be in short supply and indicates that detained individuals and staff wear cloth face coverings. In precautions for using this mask, it does not recognize the need for social distancing even when masks are worn, which is especially important considering that cloth face coverings do not provide the same level of protection as N-95 masks.
 - b) The April 10 guidance states that masks should be changed at least daily, but both individuals reported detainees receiving only one mask at the end of April, and no replacements in the weeks since (Declarations of Mkrtchian and Yanes).
 - c) The May 11 Status Report lacks specificity about key aspects of the COVID response related to PPE. For example, paragraph 8(x) states that, in response to inmate requests for “more access to Personal Protection Equipment (PPE) such as gloves and procedural masks,” the facility “has provided”; paragraph 17 indicates that “Procedural face masks have been distributed to staff and detainees” and that the facility has obtained additional masks. There is no information on replacing or washing masks.
 - d) The Status Report refers to masks in two other instances: in paragraph 11(a) it indicates that if a detainee tests positive for COVID-19, the facility will give the detainee a mask to wear and 11(e) indicates staff that interact with positive cases will wear a mask. Paragraph 11(e) further states that staff will instruct

other detainees in the unit where the positive case is identified to “wear masks when outside their cells.” This implies that potential close contacts—detainees in the same unit as a confirmed positive case—will not wear a mask while inside their cells, potentially exposing others if they are infected.

- e) Wyatt does not state that staff and detainees are *required* to wear masks (unless there is a *confirmed* COVID-19 case in their unit). Face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Wyatt states that hand sanitizer is currently only available upon request, and that standalone sanitizer kiosks are not yet available. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it; replacing the mask with a new one if it becomes damp (e.g., from sneezing); and not to re-use single-use masks.
- f) Individuals have reported that many of the guards and detainees do not wear the masks even when around others (Declarations of Mkrtchian and Yanes).
- g) There are times when detainees will necessarily not be able to wear masks, for example, during meals. In these instances, detainees should eat individually or with proper distancing from others. However, Wyatt acknowledges that it still regularly sits at least two detainees together at small, round tables just three to four feet across, where detainees sit less than an arm’s length from each other.

39. **Apparent Failures to Comply with Stated Protocols:** Even where Wyatt states it has instituted measures to mitigate risk of infection, discrepancies between Wyatt’s stated policies and the declarations of individuals detained at Wyatt provide a basis for concerns that those purported policies are not being implemented. For example, Wyatt states that it is “[i]mplementing an enhanced cleaning protocol,” that now includes “[c]leaning frequently throughout the day and disinfecting tables, chairs, handrails, phone handsets, and other high-touch areas” at unspecified intervals. However, there is no indication that shared objects and facilities like showers, telephones, and tables are being disinfected *between uses*. Wyatt states that “additional” soap and cleaning materials will be provided, but individuals detained at Wyatt report going weeks without soap, and limited access to paper towels for personal use. Additionally, Wyatt states that detainees will be provided with guidance to reduce COVID-19 related risks, but individuals report that the Warden stated that only people showing symptoms are contagious, and that people would only get tested if they show symptoms for 16 days.

Conditions and Risk of COVID-19 Transmission at Wyatt

40. Based upon the declarations I reviewed, I have identified the following vectors of COVID-19 infection at Wyatt:
- a) Crowding and inability to practice social distancing (e.g., sharing pods with 60 people spread across two floors, with small cells in which detained individuals cannot practice social distancing (e.g. two to a cell with bunk beds); communal meal times and recreation in areas that are so small that detainees may be a few inches apart from one another on each side) (Declarations of Mkrtchian and Yanes).
 - b) Potential exposure via a large number of people sharing facilities and objects (like medicine cart, tables, and phones) not frequently disinfected; limited number of toilets and showers shared among unit (Declarations of Mkrtchian and Yanes).
 - c) Lack of professional or trained cleaning of common areas and shared objects, relying on detainees to clean spaces and surfaces (Declarations of Mkrtchian and Yanes).
 - d) Limited access to hygiene products including soap, paper towels and hand sanitizer (Declarations of Mkrtchian and Yanes).
 - e) Minimal or inconsistent use of PPE by guards (Declarations of Mkrtchian and Yanes).
 - f) Availability of a single cloth mask with no instructions for use (Declarations of Mkrtchian and Yanes).
 - g) Lack of isolation or temperature checks after potential exposure to COVID-19 positive individual (Declarations of Mkrtchian and Yanes).
 - h) Lack of testing, even when a detainee presents some COVID-19 symptoms (Declarations of Mkrtchian and Yanes).
41. Based upon the May 11 Status Report, the number of staff tested is “self-reported by [the] staff,” indicating that Wyatt itself is apparently not testing its staff *at all* or testing its staff but allowing the staff to self-report the result.

Heightened Rates of COVID-19 Infection and Spread Within Detention Facilities

42. The rates of spread in the facilities that have been testing for COVID-19 illustrates the dangers the conditions in Wyatt pose to those who are detained there, and to the broader community. The highest rates of infection have been detected in jails like the Cook County Jail in Chicago and Marion Correctional Institution in Ohio.⁷² In Marion, as mentioned above, as of April 25, over 2,000 people—more than 80% of all

⁷² *Coronavirus in the U.S.: Latest Map and Case Count*, THE N.Y. TIMES (updated May 11, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.

inmates—have tested positive,⁷³ and five inmates and one correctional officer have died.⁷⁴ Notably, the Ohio Department of Rehabilitation & Correction noted that they “were getting positive test results on individuals who otherwise would have never been tested because they were asymptomatic.”⁷⁵

43. At Rikers Island in New York, on Saturday March 21, a jail oversight agency indicated that 21 inmates and 17 employees tested positive.⁷⁶ As of April 5, 273 inmates at Rikers and 321 correctional staff across the New York City jail system had tested positive for COVID-19; 1 inmate and 4 corrections officers have died.⁷⁷ The Legal Aid Society in New York recently reported that the infection rate for COVID-19 at local jails is more than seven times higher than the rate citywide and 87 times higher than the country at large.⁷⁸
44. Similarly, the documented rates at Cook County Jail illustrate how quickly COVID-19 can spread within prison and jail walls. In a matter of two days, the number of individuals infected jumped from 38 inmates⁷⁹ to 89 inmates and 12 staff members.⁸⁰ In a few weeks, the jail had 987 confirmed cases,⁸¹ with numbers rising even after the release of several hundred individuals.⁸² The only institutions that have higher numbers are four other correctional institutions (including Marion in Ohio) and one pork processing facility.⁸³

⁷³ Sarah Volpenhein, *Marion Prison Coronavirus Outbreak Seeping Into Larger Community*, MARION STAR (Apr. 25, 2020), <https://www.marionstar.com/story/news/local/2020/04/25/marion-prison-ohio-coronavirus-outbreak-seeping-into-larger-community/3026133001/>.

⁷⁴ Mohammed Syed and Jareen Imam, *Inmates Fear Death as Ohio Prison Is Overwhelmed by Coronavirus*, NBC NEWS (Apr. 29, 2020), <https://www.nbcnews.com/news/us-news/inmates-fear-death-ohio-prison-overwhelmed-coronavirus-n1194786>.

⁷⁵ Josiah Bates, *Ohio Began Mass Testing Incarcerated People for COVID-19. The Results Paint a Bleak Picture for the U.S. Prison System*, TIME (Apr. 22, 2020) <https://time.com/5825030/ohio-mass-testing-prisons-coronavirus-outbreaks/>.

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

⁷⁷ Josiah Bates, *New York’s Rikers Island Jail Sees First Inmate Death From COVID-19*, TIME (Apr. 6, 2020), <https://time.com/5816332/rikers-island-inmate-dies-coronavirus/>.

⁷⁸ *Coronavirus Update: Rikers Island Rate of Infection 7 Times Higher Than Citywide, Legal Aid Says*, CBS NEW YORK (Mar. 26, 2020, 5:24 PM), <https://newyork.cbslocal.com/2020/03/26/coronavirus-rikers-island>.

⁷⁹ *Cook County Jail Says 17 Inmates Have Tested Positive for Coronavirus*, NBC CHICAGO (last updated Mar. 25, 2020), <https://www.nbcchicago.com/news/local/cook-county-jail-says-17-inmates-have-tested-positive-for-coronavirus/2244652/>.

⁸⁰ Josh Gerstein, *Federal Prisons Mark First Virus Death*, POLITICO (Mar. 29, 2020), <https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387>.

⁸¹ *Coronavirus in the U.S.: Latest Map and Case Count*, THE N.Y. TIMES (updated May 11, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.

⁸² *167 Cook County Jail Detainees Have Tested Positive for COVID-19, Officials Say*, NBC CHICAGO (Apr. 1, 2020), <https://www.nbcchicago.com/news/local/167-cook-county-jail-detainees-have-tested-positive-for-covid-19-officials-say/2248892/>.

⁸³ *Coronavirus in the U.S.: Latest Map and Case Count*, THE N.Y. TIMES (updated May 11, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.

45. The numbers of confirmed cases is starting to follow a similar exponential trajectory. On April 15, about 4 weeks ago, 91 ICE detainees had tested positive for COVID-19.⁸⁴ As of May 11, 2020, that number has jumped to 869.⁸⁵ Moreover, 42 employees at ICE facilities and 102 ICE employees not assigned to detention facilities have reported confirmed cases.⁸⁶
46. The data above also confirms high rates of infection among correctional officers and other staff. These individuals all face an increased risk of COVID-19 exposure as they are less able to practice the recommended strategy of social distancing in carrying out their official duties. If corrections officers are significantly affected by COVID-19, whether through being infected, exposed by detainees, their fellow officers or in the community, large numbers will be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

Infrastructure in Detention Facilities and Surrounding Communities Will Likely Be Insufficient to Address Needs of COVID-19 Patients.

47. As COVID-19 enters into the immigration detention facilities, these facilities will likely be unable to address the needs of infected individuals due to lack of testing and insufficient physical and medical infrastructure.
48. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. The May 11 Status Report states that Wyatt will ensure 24/7 presence of on-site nursing staff. However, it can assure the presence only of “at least two registered nurses onsite during first and second shift, and at least one registered nurse on site during third shift”—and makes no assurance at all as to the presence of any on-site physician during any hour of the day. Moreover, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Based on my review of declarations, it appears that, even without a public health crisis, it is a challenge for Wyatt to provide appropriate medical care to its detainees (Declarations of Mkrtchian and Yanes). A COVID-19 outbreak would put severe strain on this already strained system.
49. Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in communities in which these detention facilities are located. In the paper posted online in the *Journal of Urban Health*, examining COVID-19 transmission in 111 ICE detention facilities, the authors found that local ICU capacity

⁸⁴ Screenshot on file with author.

⁸⁵ *ICE Guidance on COVID-19*, U.S. IMMIGRATION AND CUSTOMS ENF'T, <https://www.ice.gov/coronavirus> (last accessed May 11, 2020).

⁸⁶ *Id.*

within a 10-and 50-mile radius of each facility was often overwhelmed.⁸⁷ On April 15, Dr. Deborah Birx, Coronavirus Response Coordinator for the White House Coronavirus Task Force, singled out Rhode Island and the Providence area specifically, as in a uniquely concerning situation because the area is “caught between two incredible [coronavirus] hot spots in the country”: first, the Providence area “had increasing cases from the New York City area and now they have an increase in cases from the Boston area.”⁸⁸

50. Given the likelihood of continued community transmission and the potential for second and third “waves” with sharply increased incidence of infection,⁸⁹ long-term strategies are needed to manage the risk of COVID-19 in detention facilities. Prolonged segregation (e.g., due to quarantine) is not an ideal solution for people without symptoms or confirmed disease. Detainees who are segregated are monitored less frequently and if they develop symptoms, they may not be able to get the medical attention they need in a timely fashion. In his declaration of April 17, Warden Martin stated that “Also, my experience is that detainees who successfully integrate and congregate with others tend to do better during their time at the Facility than those who are on lockdown or in isolation. I believe that it is important to get new detainees acclimated and integrated into the general population where they can socialize, recreate with others, and establish connections. I am also aware and understand that suicide rates for prisoners and detainees are disproportionately higher within the first several days of detention.” The current practice of a 16-day lockdown for new detainees, increases the risk, as the Warden attests, of suicide or self-harm, giving rise to more medical problems in the midst of a pandemic. Isolation can also increase the amount of physical contact between staff and detained people and increased use of force due to the increased psychological stress of isolation. Fear of being placed in solitary may also deter people from reporting symptoms to correctional staff. This avoidance of reporting symptoms or illness would not only accelerate the spread of infection within facilities but could increase the likelihood of prisoner deaths due to lack of treatment.

Conclusions

51. CDC guidance on correctional and detention facilities,⁹⁰ posted March 23, 2020, reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at “heightened” risk for COVID-19 infection once the virus is introduced; 2) There are many opportunities for COVID-19 to be

⁸⁷ Michael Irvine et al., *Modeling COVID-19 and Impacts on U.S. Immigration and Customs Enforcement (ICE) Detention Facilities*, 2020, Journal of Urban Health 2020, https://whistleblower.org/wp-content/uploads/2020/04/Irvine_JUH_ICE_COVID19_model.pdf (last accessed May 11, 2020).

⁸⁸ Betsy Klein, *Birx concerned Rhode Island reemerging as Covid-19 hotspot*, CNN (Apr. 15, 2020, 6:38 pm), https://www.cnn.com/asia/live-news/coronavirus-pandemic-intl-04-15-20/h_af7368925ea3d84fd67369e9e6ac0559.

⁸⁹ Kristine A. Moore, et al., *COVID-19: The CIDRAP Viewpoint: Part 1: The Future of the COVID-19 Pandemic: Lessons from Pandemic Influenza*, CENTER FOR INFECTIOUS DISEASE RESEARCH & POLICY, UNIV. OF MINNESOTA (Apr. 30, 2020), https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf.

⁹⁰ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html> (last updated Mar. 23, 2020).

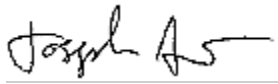
introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

52. Based on Petitioners' declarations and the May 11 Status Report, Wyatt is not following (and is not able to follow) CDC guidance in relation to social distancing, putting all detainees in jeopardy, especially those at high risk of severe disease and death.
53. Even if ICE is to implement its own guidance at the facilities, it will not prevent the spread of COVID-19 because of the potential for asymptomatic transmission from other detainees or ICE facility staff of COVID-19.
54. Although the ICE guidance states that individuals at epidemiologic risk will be housed separately, based upon the Petitioners' declarations, this practice is not being implemented. Nor is there clarity as to what separate housing looks like: housing people who are not confirmed positives with people who are symptomatic creates a grave risk of transmission. This puts Petitioners at increased risk for exposure to COVID-19 as discussed above. The close quarters, the lack of testing and the inability to enforce appropriate social distancing are an urgent problem. Procedures that may have worked for other outbreaks, like flu, will not be sufficient to control COVID-19 and physical distancing is essential.
55. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.
56. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released to home quarantine for 14 days. Where there is not a suitable location for home quarantine available, these individuals could be released to housing identified by the county or state Department of Health.
57. Other individuals who may not be identified as high risk should also be considered for release. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees and lessen the burden of ensuring the safety of detainees and corrections officers.

58. Given the physical infrastructure of facilities, the challenges of providing security without close contact, and the lack of proper equipment (such as sufficient numbers of masks) to prevent transmission, I do not believe detention facilities are equipped to ensure the safety of those in their custody. Releasing individuals at highest risk who can then self-isolate—either in their homes or in facilities arranged by the local department of health—provides a significantly better likelihood of preventing infection, disease spread and death, both in the facility and in the community at large.

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

Executed this 12th day of May, 2020 in Princeton, New Jersey.

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

Joseph J. Amon, PhD MSPH

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EDUCATION

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

ACADEMIC APPOINTMENTS

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

TEACHING EXPERIENCE

Professor

| | | |
|----------------|----------------------|---|
| 2019 - Present | Drexel University | Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate) |
| 2011 – 2018 | Princeton University | Health and Human Rights (undergraduate) Epidemiology (undergraduate) |
| 09-12/2012 | SciencesPo | Health and Human Rights (graduate) |

Co-Instructor

| | | |
|-----------|---|-------------------------------------|
| 2012-2013 | Global School of Socioeconomic Rights, Harvard University | Health Rights Litigation (graduate) |
|-----------|---|-------------------------------------|

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

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

Advisory

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

FULL-TIME WORK EXPERIENCE

- 09/2018-Present **Drexel University, Dornsife School of Public Health, Philadelphia, PA.**
- *Director, Global Health*
- *Clinical Professor, Dept of Community Health and Prevention*
- 02/2016–08/2018 **Helen Keller International, New York, NY.**
- *Vice President, Neglected Tropical Diseases*

Provided strategic, technical and overall management for >\$125m portfolio of work on NTDs. Led development of proposals resulting in >\$80m in new projects.
- 08/2005–01/2016 **Human Rights Watch, New York, NY.**
- *Director, Health Division (Sept 2008 – Jan 2016)*
- *Founded Disability Rights Division (2013); Environment Division (2015)*
- *Director, HIV/AIDS Program (August 2005 – August 2008)*

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.
- 07/2003–06/2005 **Centers for Disease Control and Prevention, Atlanta, GA.**
- *Epidemiologist, EIS Officer*

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.
- 07/2000–09/2002 **Walter Reed Army Institute of Research, Silver Spring, MD.**
- *Research Fellow*

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.
- 07/1995–06/1998 **Family Health International, Arlington, VA.**
- *Technical Officer (Jan – June 1998)*
- *Evaluation Officer (Aug 1996 – Dec 1997)*
- *Associate Evaluation Officer (July 1995 – July 1996)*

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.
- 09/1992–11/1994 **U.S. Peace Corps, Lomé, Togo.**
- *Volunteer*

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

SHORT-TERM AND CONSULTING EXPERIENCE

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

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- 4 **Amon JJ**. *Preventing HIV Infections in Children and Adolescents in Sub-Saharan Africa through Integrated Care and Support Activities*. African Journal on AIDS Research. 2002; 1(2):143-9.
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- 11 Ryan JR, Stoute JA, **Amon J**, Dunton RF, Mtalib R, Koros J, Owour B, Luckhart S, Wirtz RA, Barnwell JW, Rosenberg R. *Evidence for Transmission of Plasmodium Vivax among a Duffy Antigen Negative Population in Western Kenya*. American Journal of Tropical Medicine and Hygiene. 2006 75(4):575-81.
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- 2 *Knowledge, attitudes and behaviors related to Guinea Worm Eradication, Togo*. IV West African Guinea Worm Eradication Conference, Ouagadougou, Burkina Faso, October 1994.
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- 5 *HIV/AIDS and Adolescents in Ukraine*. Ukrainian-American Medical Society Annual Meeting. Philadelphia, PA, May 2003.
- 6 *Expanding HIV testing and respecting rights*. International conference on HIV/AIDS and Human Rights. Smolny College. St Petersburg, Russia. October 2005.
- 7 *HIV in Conflict Settings*. Joint Congressional Human Rights Caucus meeting. Washington DC. March 2006.
- 8 *Reflections and recollections*. Masters Internationalist - US Peace Corps Symposium. Washington DC. April 2006. (Keynote)
- 9 *Civil Society Participation in the Response to HIV/AIDS and Accountability*. Presented in panel 1: Breaking the cycle of infection for sustainable AIDS responses. United Nations General Assembly Special Session on HIV/AIDS. New York. June 2006.
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- 12 *Burma, HIV and Human Rights*. Asia Society. New York. September 2007.
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- 16 *Promoting Public Health and Human Rights in MDR-TB Care*. International Union against Lung and Tuberculosis Disease. Paris, France. October 2008.
- 17 *Public Health and Human Rights: Challenges around the World*. New York Academy of Sciences and Johns Hopkins School of Public Health Conference on Public Health and Human Rights. New York, NY. Dec 2008.

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- 19 *Rights-based approaches to health*. Interaction Annual Meeting. Arlington, VA. July 2009. (panel moderator)
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- 21 *HIV in Asia*. Asia Society. December 1, 2010.
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- 23 *Human Rights Perspective*. International Workshop on Treatment as Prevention. Vancouver, Canada. May 2011.
- 24 *Sustaining Environmental, Occupational and Public Health and Community Security: Lead Poisoning in China and Nigeria*. 12th National Conference on Science, Policy and the Environment. Washington, DC. January 2012.
- 25 *Health and Human Rights in Prisons*. European Infectious Disease meeting. Italy. September 2012. (Keynote)
- 26 *Measuring Violence against Children and the Effectiveness of Violence Prevention and Reduction Initiatives*. Columbia University. October 2013. (Panel Discussion Moderator)
- 27 *Political Epidemiology of HIV*. HIV 2014: Science, Community and Policy for Key Vulnerable Populations. New York Academy of Sciences. May 2014.
- 28 *On the Radar: Police Brutality, Politics & Public Health*. Princeton University. March 2015.
- 29 *Global Inequalities of Wealth and Health*. Bernstein Institute for Human Rights Annual Conference. New York University School of Law. April 2015.
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- 32 *Global Health and Governance*. Brookings Institution. May 2016.
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- 4 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Behavioral explanations for elevated prevalence of HIV in St. James Parish, Jamaica*. XII Int Conf AIDS. 1998; 12:216-7 (abstract no. 14171).
- 5 D'Angelo LA, **Amon J**, Lemos ME, Rebeiro MA, Gitchens W, Kotellos K. *Evaluating capacity building of implementing agencies in the AIDSCAP Brazil project*. XII Int Conf AIDS. 1998;12:945 (abstract no. 43503).
- 6 Saidel T, Mills S, **Amon J**, Rehle T. *Behavioral Surveillance Surveys (BSS) on specific target groups: a valuable complement to standardized general population surveys*. XII Int Conf AIDS. 1998;12:233 (abstract no.14256).
- 7 Essah KAS, Jackson D, Attafuah JD, **Amon J**, Yeboah KG. *Findings from the 2000 behavioral surveillance survey in Ghana*. XIV International AIDS Conference: Abstract no. C11062
- 8 Chatterji M, Murray N, Dougherty L, Alkenbrack S, Winfrey B, **Amon J**, Ventimiglia T, Mukaneza A. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia*. XV Int Conf on AIDS, 2004 (Abstract WePeD6602).
- 9 Murray NJ, Chatterji M, Dougherty L, Winfrey B, Buek K, **Amon J**, Mulenga Y, Jones A. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia*. XV Int Conf on AIDS, 2004 (Abstract TuOrD1218).
- 10 **Amon J**, Devasia R, Xia G, *et al*. *Molecular Epidemiologic Investigation of Hepatitis A Outbreaks, 2003*. 4th International Conference on Emerging Infectious Disease, Atlanta, GA, March 2004.
- 11 **Amon J**, Devasia R, Xia G, *et al*. *Multiple Hepatitis A Outbreaks Associated with Green Onions among Restaurant Patrons – Tennessee, Georgia, and North Carolina, 2003*. 53rd EIS Conference, Atlanta, GA, April 2004. (Winner, Mackel Award)
- 12 Chatterji M, Murray N, Dougherty L, Ventimiglia T, Mukaneza A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia*. International Union for the Scientific Study of Population XXV International Population Conference Tours, France, July, 2005.
- 13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia*. International Union for the Scientific Study of Population. International Population Conference France, July, 2005.
- 14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J**. *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

- 15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.
- 16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.
- 17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J.** *Local and cultural beliefs about HIV transmission fuel children's rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.
- 18 Cohen J, Epstein H, **Amon J.** *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.
- 19 Schleifer R, Skala P, Lezhentsev K, **Amon J.** *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.
- 20 **Amon, J.** *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.
- 21 Ngonyama L, Lohman D, Clayton M, **Amon J.** *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.
- 22 Lohman D, Ovchinnikova M, **Amon J.** *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.
- 23 **Amon J.** *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.
- 24 Lohman D, Ngonyama L, Clayton M, **Amon J.** *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.
- 25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province.* XVII International AIDS Conference: Abstract no. THPE1085. August 2008.
- 26 **Amon J.** *Protecting the human rights of people at risk of and affected by TB.* 3rd Stop TB Partners Forum, Rio March 2009
- 27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009
- 28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.
- 29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.
- 30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.
- 31 **Amon J.** *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.
- 32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

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

- 33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.
- 34 Pearshouse R, **Amon JJ.** *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.
- 35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J.** *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202
- 36 Jones L, Akugizibwe P, **Amon J,** et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033
- 37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J.** *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAFO101
- 38 McLemore M, Winter M, **Amon J.** *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942
- 39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J.** *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)
- 40 Pearshouse R, Cohen JE, **Amon J.** *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203
- 41 Lohman D, Palat G, Nair S, **Amon J,** Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.
- 42 Kippenberg J, Thomas L, Lohman D, **Amon J.** *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.
- 43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.
- 44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.
- 45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.
- 46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.
- 47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)
- 48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.
- 49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.
- 50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.
- 51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.
- 52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)
- 53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

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

- 54 **Amon J.** *Enhanced HIV testing in the context of human rights.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.
- 55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.
- 56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination.* International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.
- 57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)
- 58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ**, et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.
- 59 **Amon J.** *Epidemic transition: How will we achieve it while ensuring equity and quality?* 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

- 1 University of North Carolina School of Public Health (March 2006)
- 2 Duke University School of Public Policy (October 2006)
- 3 University of Chicago (October 2006)
- 4 University of Toronto Law School (November 2006)
- 5 Columbia University Law School (Dec 2006, 2007, 2009)
- 6 University of Denver School of International Affairs (March 2007)
- 7 Georgetown University Law School (April 2007)
- 8 Columbia University School of International and Public Affairs (Feb and Oct 2007)
- 9 University of Connecticut School of Law (April 2009)
- 10 New York University (January 2011, November 2014)
- 11 University of Zurich (September 2011)
- 12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)
- 13 Yale University Law School (March 2013)
- 14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)
- 15 UCLA Law School (January 2014)
- 16 Stanford University Law & Medical Schools (January 2014)
- 17 University of Melbourne, Nossal Institute for Global Health (July 2014)
- 18 Fordham Law School (October 2014)
- 19 Northwestern University (November 2014; Nov 2015)
- 20 Dornsife School of Public Health, Drexel University (February 2018)
- 21 University of California San Diego (March 2018)

AWARDS

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

AD HOC REVIEWER

Journals:

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

Grants:

Open Society Foundations, Public Health Program