Declaration of Dr. Ranit Mishori (MD, MHS, FAAFP)

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

I. Background

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and Professor of Family Medicine at the Georgetown University School of Medicine, where I am the director of the department’s Global Health Initiatives, Health Policy fellowship and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master’s degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).

2. I am the faculty leader for Georgetown University School of Medicine’s Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons and detention centers. In addition, I am the director of Georgetown University’s Asylum program which focuses on the care and medico-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.¹

3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants and refugees.

I routinely come in contact with victims of abuse, trauma and poverty where I regularly assess their medical as well as psycho-social needs in the context of their social-determinants of health (such as housing and incarceration).

4. For four years I was an elected member of the American Academy of Family Physicians’ Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a one of the lead authors of the Academy’s comprehensive position paper on Incarceration and Health.

5. My CV is attached as Exhibit A.

II. COVID-19

6. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. COVID-19 has now reached pandemic status. As of March 25, 2020, according to the World Health Organization (WHO), more than 416,686 people have been diagnosed with COVID-19 around the world and 18,589 have died. In the United States, about 51,914 people have been diagnosed and 673 people have died as of the same date. The numbers of infection and death in the United States are likely underestimated due to the lack of test kits available.

7. The transmission of SARS-CoV-2 is expected to grow exponentially. Nationally, projections by the Centers for Disease Control and Prevention (CDC) indicate that over 200 million people in the United States could be infected with SARS-CoV-2 over the course of the pandemic without effective public health intervention, with as many as 1.5 million deaths in certain projections.

8. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but also survives on surfaces for some period of time. It is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where SARS-CoV-2 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. The “contagiousness” of this novel coronavirus—its R0 (the number of people who can get infected from a single infected person)—is twice that of the flu. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune

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systems have never been exposed to or developed protective responses against this virus.

9. COVID-19 is a serious disease, which can lead to respiratory failure, kidney failure, and death. Older patients and patients with chronic underlying conditions are at a particularly high risk for severe cases and complications.\textsuperscript{4} The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems. According to preliminary data from China, serious illness, sometimes resulting in death, occurs in up to 16% of cases, with a higher rate among those older and high-risk individuals.\textsuperscript{5}

10. The CDC previously identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including: blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

11. Those in high-risk categories who do not die may have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are likely to soon be in very short supply, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.

12. Complications from COVID-19, including severe damage to lung, heart, liver, or other organs, can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.

13. COVID-19 shares many symptoms with seasonal influenza, including fever, body ache, cough, chills, and headache. Without testing, it is difficult for healthcare


providers to ascertain whether an individual with these symptoms is suffering from COVID-19 or seasonal influenza.

14. There is no vaccine to prevent COVID-19. There is no known cure or antiviral treatment for COVID-19 at this time.

15. COVID-19 prevention strategies include containment and mitigation. Containment requires identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Unfortunately, due to the lack of testing availability, most public health experts agree that it is too late to effectively implement a containment strategy in the United States at-large.

16. As the infectious disease spreads in a community, public health demands mitigation strategies, which include scrupulous hand hygiene and social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of coronavirus. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of this risk mitigation strategy. On March 19, 2020, California Governor Gavin Newsom issued an order for all residents of the state to stay at home except as needed to maintain critical infrastructure.6

III. Spread of Infectious Disease in Detention Centers

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

18. Globally, outbreaks of contagious diseases are all too common in confined detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. ICE has temporarily suspended social visitation in all detention facilities.7 However, staff arrive and leave on a shift basis; there is no ability to adequately screen staff for new, asymptomatic infection. Contractors and vendors also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities. As discussed in Section IV below, ICE has further increased the risk of exposure by continuing to carry out raids that introduce new people into detention centers during this pandemic.

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19. Jails, prisons and detention centers often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits.

20. During an infectious disease outbreak, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Detention centers are often under-resourced and ill-equipped to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak. This is especially true when, as now, facemasks are already in short supply.

21. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Congregate settings such as detention centers allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. Toilets, sinks, and showers are shared, without disinfection between use. Spaces within detention centers are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world—including their family and lawyers. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

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

23. People incarcerated in detention centers are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community. This is because people in detention centers, jails, and prisons, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and

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suppressed immune systems from HIV or other conditions, than people in the community.

24. Detention centers are often poorly equipped to manage infectious disease outbreaks. Some detention centers lack onsite medical facilities or 24-hour medical care. The medical facilities are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized negative pressure rooms. Most detention centers have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). ICE has admitted that not all of the detention centers it oversees have even one negative pressure room.9 In the course of an infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.

25. Even assuming adequate space, solitary confinement is not an effective disease containment strategy. Isolation of people who are ill using solitary confinement is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms, air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in the detention center and staff. This makes both containing the illness and caring for those who have become infected much more difficult.

26. Infectious disease outbreaks, such as COVID-19, may exacerbate existing mental health conditions and contribute to the development of new mental health conditions.10 Mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. Moreover, failure to provide adequate mental health care, as may happen when health systems in detention centers are taxed by an infectious disease outbreak such as COVID-19, may result in poor health outcomes and even death. The scientific evidence points to a bi-directional relationship between mental health conditions and infectious diseases. Not only are individuals with mental health conditions more at risk for communicable diseases, they are also harder to treat, once infected, due to the


nature of their underlying mental health disorder. For individuals in these facilities, especially those with chronic mental health conditions, the experience of an epidemic and the lack of care while confined to small, crowded quarters can itself be traumatizing, compounding the trauma of incarceration.

27. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon enough many are sick—including high-risk groups such as those with chronic conditions—quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may be transferred.

28. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.11 Subsequent CDC investigation of 995 inmates and 235 staff members across the two facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.12 H1N1 is far less contagious than this strain of the coronavirus. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

29. In recent years in immigration detention facilities, overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of other infectious diseases as well, including mumps and chickenpox.

30. Additionally, as health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions.

31. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of SARS-CoV-2. Not surprisingly, Chinese prison officials report that over 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined.

11 Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011, Centers for Disease Control and Prevention, Apr. 6, 2020, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

32. Many detention centers in the United States have a high risk of exposing detainees to SARS-CoV-2. At least ten facilities currently used as ICE jails hold on average over 1,000 detainees, including 1,600 in the Adelanto ICE Processing Center.\(^{13}\) In addition, ICE has in recent years begun detaining an increasing number of people in detention centers whose remote locations make the provision of adequate medical care challenging even under normal circumstances.

33. In my professional opinion, it is inevitable that SARS-CoV-2 the virus that causes COVID-19 will infect prisons, jails, and/or other immigration detention centers in the United States. This is consistent with the prediction of other experts that all prisons and jails should anticipate that the coronavirus will enter their facility.

IV. Los Angeles Area ICE Raids

34. In the Los Angeles area, hit hard by the coronavirus and COVID-19, 814 people had tested positive as of March 25, 2020. That number is also growing exponentially.

35. Based on reporting and the testimony of Plaintiffs in their declarations, ICE continues to carry out immigration enforcement raids in the Los Angeles area. According to the LA Times, on Monday, March 16, 2020, well after known community transmission of COVID-19 had begun in the Los Angeles area, ICE officers conducted morning raids in an attempt to arrest four individuals.\(^{14}\) According to the testimony of Plaintiff Luis Vasquez Rueda, ICE transported eight individuals to Adelanto Detention Center in a single van alone on March 17, 2020, after conducted morning raids that same day.

36. Based on my review of declarations in which Plaintiffs describe the actions taken by ICE officers during those raids and my training in public health, conducting these raids was a reckless decision by the government that unnecessarily put countless people at risk of exposure to the coronavirus.

37. Conducting immigration raids in the midst of a pandemic simultaneously increased the risk of introducing the coronavirus into the Adelanto Detention Center and has now placed the newly detained individuals at a higher risk of infection than they would have experienced while following California’s shelter in place orders at home.

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38. Based on my decades of professional experience in public health, the risks of conducting ICE raids in the midst of an infectious disease pandemic are clear. There is a captive population in immigration detention and a revolving door of exposure whenever raids are conducted, and when staff members and ICE officers cycle in and out of facilities for their shifts. Anyone, including ICE officers and detained persons, can carry infection with them, in either direction.

39. The recent Los Angeles area raids introduced new people, including Plaintiffs, into the Adelanto detention facility. Any of these people could have been affected by asymptomatic community transmission of the novel coronavirus prior to their detention, which experts know was occurring in the Los Angeles region at the time of the raids.

40. The raids also led ICE officers to interact with individuals in close quarters, which according to Plaintiffs included prolonged physical contact and close proximity without masks during the arrests. This blatantly ignores current CDC guidelines to minimize any exposure at this critical moment in the pandemic, by practicing social distancing (6ft), disinfecting hard surfaces (police car seats, handcuffs, etc.), or by hand sanitizing.

41. The officers likely also had contact with additional staff at Adelanto during the processing of plaintiffs and other detainees. Those officers will return to their communities having experienced close contact with various people, potentially exposing other members of their community who are otherwise following California’s shelter in place orders.

42. Raids such as these endanger detainees, but also all who come in contact with migrants, from immigration enforcement staff to workers at detention facilities. All those people come in contact with the detainees and go home to their families at night.

43. By conducting any raids in the midst of this pandemic, ICE greatly increases the risk of spreading the coronavirus within their facilities, with potentially devastating consequences. ICE also risks exposing currently healthy individuals to a far more dangerous situation than the shelter-in-place conditions currently being observed by the rest of Californians. The raids simultaneously raise the likelihood of wider community exposure across communities where officers and their families live.

V. Adelanto Detention Center

44. Based on my review of the plaintiffs’ declarations, my experience working with detainees in local jails and immigration centers, my experience working with the formerly incarcerated, my training in public health, and my review of the relevant literature, it is my professional judgment that the Adelanto Detention Center, where
Plaintiffs are currently held, is dangerously under-equipped and ill-prepared to prevent and manage a coronavirus outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

45. The Adelanto Detention Center holds over 1,600 people in detention. The facility has an extremely poor track record for the health and safety of detainees, underscoring and potentially exacerbating the already significant risks of a coronavirus outbreak in detention facilities I describe above.


47. Given the grave concerns expressed by the federal government regarding the health and safety of detainees at Adelanto, as well as the descriptions from Plaintiffs regarding steps the facility is currently taking in response to COVID-19, it is my professional opinion that detainees in the facility are at high risk of exposure to the coronavirus, and an outbreak in the facility has the potential to become a devastating public health event.

48. It is my professional opinion that the facilities are particularly susceptible to rapid spread of the virus and are not equipped to handle a coronavirus outbreak.

49. The living conditions are not amenable to the necessary social distancing and hygiene measures that would be necessary to contain or minimize spread of the virus. In particular, the fact that persons detained in those facilities share dorms, cells, living spaces, and bathroom space that is not disinfected between each use, and regularly interact with each other in narrow hallways and other areas where maintaining distance is not possible, makes it all but inevitable that the virus would spread rapidly within the facility.


50. Because routine testing is not being undertaken at the facility, it is impossible to tell how many asymptomatic carriers of the disease may already be at the facility or to screen for new instances of the virus before an individual with the coronavirus becomes symptomatic. Since testing is not widely available, it is highly unlikely that the facility would even be able to keep up with the need to test individuals exhibiting symptoms for the virus. Rapid spread of the virus within the facility is therefore extremely likely.

51. Medical units that share spaces exacerbates this problem, as there is no way to isolate individuals infected with the virus when this becomes necessary. The fact that there is only a small amount of space available in the medical unit makes it highly unlikely that the facility could accommodate expanded need for services as a result of a coronavirus outbreak.

52. Moreover, the minimal and part-time nature of medical staffing, and the fact that detainees appear to have had difficulties accessing routine medical care in the past render it highly unlikely that the facility would be able to provide appropriate screening or treatment should that become necessary.

VI. Conclusion and Recommendations

53. For the reasons above, it is my professional judgment that the plaintiffs in ICE’s Los Angeles-area detention centers, including the Plaintiffs currently detained in Adelanto, are at a significantly higher risk of infection with SARS-CoV-2 as compared to the population in the community, and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac and kidney failure) and even death.

54. It is also my professional judgment that the decision to conduct ICE raids during this pandemic simultaneously increased the risk of introducing coronavirus into the Adelanto Detention Center and has exposed the individuals newly brought into ICE custody to a higher risk of infection than they would have experienced sheltering in place at home. The public health of both ICE detainees and the wider community as a whole necessitates an immediate end to ICE raids during this pandemic.

55. Given that the only viable public health strategy available in the United States currently is risk mitigation, reducing the size of the population in immigration detention centers is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless given the public health realities we now face in the United States.
56. Even with the best-laid plans to address the spread of coronavirus in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my professional opinion, the only viable 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 an effective vaccine for prevention or effective treatment for the disease at this stage. My professional opinion is consistent with the view of the medical profession as a whole that there are no conditions of confinement in carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.

57. Releasing people from incarceration and ceasing enforcement actions that bring new people into detention are the best and safest ways to prevent the spread of disease and reduce the threat to the most vulnerable incarcerated people. These steps will reduce the burden on these facilities’ limited healthcare infrastructure, as they will lessen the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. They will also reduce the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population. It is my professional opinion that these steps are both necessary and urgent. The window of opportunity is rapidly narrowing for mitigation of COVID-19 in these facilities. It is a matter of days, not weeks. Once a case of coronavirus is identified in a facility, it will likely be too late to prevent a widespread outbreak.

58. It is also my professional opinion that ICE must take significant precautions against the spread of disease among any detainees, staff, and officers remaining in its facilities or involved in arrests. These precautions include: making available and mandating the use of hand sanitizer, use of gloves when handling detainees (inside the detention center or during raids), disinfecting hard surfaces frequently inside the detention centers, disinfecting equipment and tools such as handcuffs, disinfecting ICE vehicles (including seats, armrests, and door handles), facilitating social distancing among detainees, eliminating direct physical contact and close proximity of unmasked individuals including during arrests, halting the use of transport vehicles that do not allow for at least six feet of space between passengers, and other measures consistent with the CDC guidelines and California’s shelter in place order.

VII. Expert Disclosures

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

60. I am willing and able to discuss my opinions with the Court via teleconference at a mutually convenient time.
I declare under penalty of perjury that the foregoing is true and correct.

Executed this 25\(^{th}\) day of March, 2020 in Washington, D.C.


Ranit Mishori, M.D, MHS, FAAFP