UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

CRISTIAN ARRIAGA REYES, FEDOR BONDARENKO; SANTIAGO CABRERA-CAMPOVERDE; NOE CORNEJO MELENDE; ALVARO NEGRETTE MEJIA,

Petitioners-Plaintiffs,

v.

THOMAS DECKER, in his official capacity as Field Office Director, New York City Field Office, U.S. Immigration & Customs Enforcement; CHAD WOLF, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; WILLIAM P. BARR, in his official capacity as Attorney General, U.S. Department of Justice; RONALD P. EDWARDS, in his official capacity as Director, Hudson County Jail; STEVEN AHRENDT, in his official capacity as Warden, Bergen County Jail;

Respondents-Defendants.

Civil Action No. 20-cv-3600 (MCA)

FIRST AMENDED PETITION FOR WRIT OF HABEAS CORPUS PURSUANT TO 28 U.S.C. § 2241 AND COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

INTRODUCTION

1. Plaintiffs are civil immigration detainees who, by virtue of their serious and chronic medical conditions such as asthma, diabetes, and hypertension, face imminent risk of severe illness or death if they contract COVID-19 in the county jails where they are currently detained, and where the virus is already circulating. Each of the plaintiffs is subject to discretionary detention by Immigration and Customs Enforcement ("ICE") and is statutorily eligible for release at any time. But instead, they remain trapped in what are essentially tinderboxes on the verge of explosion, at grave risk to their lives and health, separated from their families during a traumatic and unprecedented public health crisis. ICE's failure to heed the advice of medical experts to release medically vulnerable individuals has created a risk of harm to Plaintiffs that is both unconscionably high and entirely preventable.

2. A growing number of courts around the country have ordered the immediate release of medically-vulnerable immigration detainees in recent days, recognizing both the enormous risk of harm that COVID-19 creates as well as ICE's failure to sufficiently abate the risk of harm. *See e.g.*, *Coronel v. Decker*, ---F. Supp. 3d---, 2020 WL 1487272 (S.D.N.Y. Mar. 27, 2020); *Avendano Hernandez v. Decker*, 20-cv-1589, 2020 WL 1547459 (S.D.N.Y. Mar. 31, 2020); *Basank v. Decker*, ---F. Supp. 3d---, 2020 WL 1481503 (S.D.N.Y. Mar. 26, 2020); *Thakker v. Doll*, 20-cv-480-EJ, Dkt. No. 47 (M.D. Penn. Mar. 31, 2020); *Bravo Castillo v. Barr*, 5:20-cv-605-TJH-AFM, 2020 WL 1502864 (C.D. Cal. Mar. 27, 2020).

3. Plaintiffs here seek the same relief in light of their pre-existing medical conditions. Packed in close quarters with other detainees and correctional staff, forced to share necessities like showers, telephones, toilets and sinks with dozens of others, and deprived of basic forms of preventative hygiene, Plaintiffs are helpless to take the key risk mitigation steps known to limit

transmission of the virus. And if they are infected, they face a heightened risk of severe illness and death within jails that have a track record of failing to provide adequate medical care even outside times of crisis.

4. Medical experts agree that reducing jail populations is critical to reducing risk during the widespread COVID-19 outbreak, and that officials must first focus on vulnerable populations to reduce harm to the entire population. Failing to heed this medical consensus and against a backdrop of extreme crisis, ICE has not sufficiently exercised its discretion to release medically-vulnerable individuals.

5. Before filing suit, Plaintiffs notified ICE of their medical conditions and requested that they be released in light of the harms they will experience if they contract COVID-19 while detained. Those pleas have fallen on deaf ears. The continued imprisonment of these high-risk individuals violates their due process rights both by constituting deliberate indifference to serious medical harm and by failing to provide procedural safeguards commensurate with the serious deprivation of life and liberty that they face.

PARTIES

6. Petitioner-Plaintiff Cristian Arriaga Reyes is a 33-year-old man who has been incarcerated by ICE since January 2020 at Hudson County Jail. He suffers from hypertension and type 2 diabetes. He is in removal proceedings at the Varick Immigration Court in New York, NY. Because of his medical conditions, Mr. Arriaga is at high risk for severe illness or death if he contracts COVID-19.

7. Petitioner-Plaintiff Fedor Bondarenko is a 35-year-old man who has been incarcerated by ICE since December 2019 at Bergen County Jail. He suffers from asthma, high blood pressure, chronic hepatitis B, acute prostatitis (deep infection of the prostate), and post-operative

complications of hemorrhoid surgery. He is in removal proceedings at the Varick Immigration Court in New York, NY. Because of his medical conditions, Mr. Bondarenko is at high risk of severe illness or death if he contracts COVID-19.

8. Petitioner-Plaintiff Santiago Cabrera-Campoverde is a 36-year-old man who has been incarcerated by ICE since February 2020 at Bergen County Jail. He has hypertension and was recently taken to the hospital due to kidney stones, for which he requires surgery. He is in removal proceedings at the Varick Immigration Court in New York, NY. Because of his medical conditions, Mr. Cabrera-Campoverde is at high risk of severe illness or death if he contracts COVID-19.
9. Plaintiff-Petitioner Noe Cornejo Melende is a 40-year old man who has been detained by ICE at the Bergen County Jail since August 2019. Mr. Cornejo Melende was recently diagnosed with Bell's Palsy and has been prescribed Prednisone, an oral steroid. Oral steroids suppress patients' immune systems. He is in removal proceedings at the Varick Immigration Court in New York, NY. Because of his neurological disorder and immunocompromised condition, Mr. Cornejo Melende is at high risk of severe illness or death if he contracts COVID-19.
10. Petitioner-Plaintiff Alvaro Negrette Mejia is a 59-year-old man who has been incarcerated by ICE since March 2019 at Hudson County Jail. He suffered a heart attack approximately five years ago and has type 2 diabetes, hypertension, and high cholesterol. He is in removal proceedings at the Varick Immigration Court in New York, NY. Because of his medical conditions, Mr. Negrette is at high risk of severe illness or death if he contracts COVID-19.
11. Respondent-Defendant Thomas Decker is named in his official capacity as the Director of the New York Field Office for Immigration and Customs Enforcement within the Department of Homeland Security. He is responsible for the administration of immigration laws and the

execution of detention and removal determinations for individuals under the jurisdiction of the New York Field Office. As such, he is a custodian of Plaintiffs.

12. Respondent-Defendant Chad F. Wolf is named in his official capacity as the Secretary of the Department of Homeland Security. He is responsible for the administration of the immigration laws pursuant to 8 U.S.C. § 1103(a); routinely transacts business in the Southern District of New York; he supervises Respondent Decker; and is legally responsible for the pursuit of non-citizens' detention and removal. As such, he is a custodian of Plaintiffs.

13. Respondent-Defendant William Barr is named in his official capacity as the Attorney General of the United States. In this capacity, he is responsible for the administration of the immigration laws as exercised by the Executive Office for Immigration Review, pursuant to 8 U.S.C. § 1103(g). He routinely transacts business in the Southern District of New York and is legally responsible for administering removal and bond proceedings and the standards used in those proceedings. As such, he is a custodian of Plaintiffs.

14. Respondent-Defendant Ronald P. Edwards is named in his official capacity as the Director of the Hudson County Jail. In this capacity, he is a custodian of two of the Plaintiffs. His office is located at the Hudson County Jail, Kearny, NJ.

15. Respondent-Defendant Steven Ahrendt is named in his official capacity as Warden of the Bergen County Jail. In this capacity, he is or was the custodian of four of the Plaintiffs. His office is located at the Bergen County Jail, Hackensack, NJ.

JURISDICTION & VENUE

16. This Court has subject matter jurisdiction over this Petition pursuant to 28 U.S.C. § 1331 (federal question); 28 U.S.C. § 2241 (habeas corpus); 28 U.S.C. § 1651 (the All Writs Act); 42 U.S.C. § 1983 (Civil Rights Act); and Article I, Section 9, clause 2 of the Constitution (the

Suspension Clause). Venue properly lies in this district under both 28 U.S.C. § 1391 and 28 U.S.C. § 2241.

STATEMENT OF FACTS

New York and New Jersey are Epicenters of an Exponentially Escalating Global Pandemic.

17. On March 13, 2020, President Trump declared a national emergency in response to the coronavirus pandemic. At the time, there were just over 1,600 confirmed cases in the United States and 46 deaths. Today, less than a month later, over 328,861 cases have been confirmed across the country and have led to the death of at least 9,368 patients.

18. New York and New Jersey are epicenters of the COVID-19 in the United States with over 160,101 identified cases in New York and New Jersey and 5,076 virus-related deaths.

19. Because the coronavirus that causes COVID-19 is particularly contagious, authorities are taking unprecedented precautions to manage the public health crisis and minimize the transmission of the virus by reducing the opportunity for large groups of people to congregate.

The Heightened Risk of Severe Illness or Death from COVID-19 in Jails

20. According to Dr. Robert B. Greifinger, who has worked in health care for prisoners for more than thirty years, "the conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions." *See* Declaration of Robert Greifinger ¶¶ 1, 9 ("Greifinger Decl.").

21. The highest known person-to-person transmission rate for COVID-19 to date has taken place in settings where people are in close proximity to each other without an ability to distance themselves: in a nursing home facility in Kirkland, Washington, and in the Cook County Jail in Chicago, Illinois.

22. The conditions of jails such as those utilized by ICE in New Jersey pose an acute risk for the spread of COVID-19 due to their close quarters, the proportion of vulnerable people detained, lack of medical care resources, and inability to seal off the facility from the outside world, given jail staff still enter and leave the facilities. Greifinger ¶¶ 10-20.
23. Preventative strategies utilized by the general public, like social distancing and preventative hygiene are not possible in jails. *Id.* ¶¶ 10.
24. When an outbreak occurs, jails holding immigrant detainees are ill-equipped to engage in adequate containment and proper medical treatment for sick detainees. *Id.* ¶¶ 11 (explaining that many immigration detention centers "lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention").
25. Medical experts agree that reducing the number of detainees is a necessary component of risk mitigation *Id.* ¶¶ 21-22. Any reduction in detained populations must focus on the most vulnerable detainees, in order to safeguard their health, the health of other detainees and jail staff, and the community as a whole. *Id.* ¶ 21.
26. As medical staff and resources within the facility becomes overwhelmed, regional hospitals and health centers end up bearing the brunt of providing healthcare for sick detainees—who are disproportionately likely to be those with pre-existing medical vulnerabilities. *Id* ¶ 23. The rapid spread of an infectious disease like COVID-19 within a jail ultimately results in adverse public health outcomes for the broader community and region.
27. In the face of the current crisis, correctional systems around the country and the world, including New York City, have announced concerted efforts to reduce their detained populations. Many of these jurisdictions are focusing their release efforts on individuals

classified as high-risk. These jurisdictions also include Los Angeles County, CA; Cook County, IL; a county in Ohio; Hennepin County, MN; and San Francisco, CA.

28. On March 22, 2020, the New Jersey Supreme Court ordered, on consent, the release of the vast majority of individuals serving county jail sentences, in light of the "profound risk posed to people in correctional facilities arising from the spread of COVID-19."

29. More recently, New York State's Department of Corrections and Community Supervision announced that it will release 1,100 individuals from the state's jails who were being held on technical parole violations.

30. Despite the consensus in the medical community about the need to reduce population size to improve outcomes for public health and safety, and in sharp contrast to the efforts of jurisdictions around the United States to comply with such recommendations, ICE has not announced plans to systematically reduce its detained population size.

The Risks to Plaintiffs' Health are Particularly Acute in the Jails Where ICE is Detaining Them.

A. Both Bergen County Jail and Hudson County Correctional Facility Reported Confirmed COVID-19 Cases.

31. The New York-area jails where plaintiffs are detained—Bergen County Jail and Hudson County Correctional Facility—are especially vulnerable to rapid transmission of COVID-19 because of the unsanitary and hazardous conditions within the facilities and their history of providing poor treatment.

32. The novel coronavirus is rapidly spreading at these jails and there are multiple confirmed cases of COVID-19 amongst ICE detainees, criminal detainees, and jail staff. Last week, a correctional officer at the Hudson County Correctional Center passed away after contracting

COVID-19. And just yesterday, officials confirmed that a nurse at the jail had also passed away after contracting COVID-19.

33. The experience of an ICE detainee at Bergen County Jail (a client of The Bronx Defenders) who tested positive for COVID-19 demonstrates ICE's lack of preparedness to deal with the consequences of its refusal to timely release medically-vulnerable detainees and its failure to prevent the virus from spreading in its facilities. Even once this individual, who had pre-existing health conditions, tested positive for COVID-19 at a local hospital, he was taken back to the jail and held there for days. Eventually, days after he was diagnosed, he was released after repeated requests by his attorney. Upon his discharge, he felt so ill that he and a family member who came to pick him up attempted to walk to the nearest hospital. However, he began throwing up shortly after leaving ICE custody and called an ambulance.

34. While confined at the jail after his positive test diagnosis, this individual was unable to contact his attorney. Additionally, despite his attorney's repeated attempts to speak to an ICE officer or jail official after learning from the client's family that he had tested positive for COVID-19, she was unable to obtain any information regarding his health or a decision on the urgent release request for over 24 hours.

B. Unsanitary Conditions and Failure to Provide Adequate Medical Care Even During Non-Crisis Times

35. ICE detainees at both jails have also reported that conditions have deteriorated in recent weeks as the facilities take ad hoc and insufficient measures to try to contain transmission, including by widespread and arbitrary use of extreme isolation at both jails. Detainees at both facilities report 23.5 hour lockdowns during which they are not permitted to leave their cells. During the 30 minutes each day that they are allowed outside their cells, they must choose between showering and calling their family or attorneys. This level of isolation from the outside world

is not only draconian, but ineffective, as detainees still share infrequently-sanitized or cleaned common spaces, telephones, and showers when allowed out of their cells.

36. Detainees also describe insufficient hand soap, hand sanitizer, and access to cleaning supplies, and previously reported at times being deprived of toilet paper. Some detainees also report that jail officials have forbidden them from flushing toilets frequently, adding to unsanitary conditions. Attorneys who visited the jails prior to the end of contact visits confirmed that there was a lack of hand soap in the visitors' bathrooms, meaning that visitors would carry in whatever germs they entered the facility with.

37. Further contributing to the elevated risk of harm is these jails' track record of failure to provide adequate and prompt medical care even before the current pandemic. *See* Declaration of Marinda Van Dalen ¶¶ 18-45. Examples of inadequate care at these specific facilities includes a history of denial of vital medical treatment such as dialysis and blood transfusions; subjecting detainees in need of surgeries to unconscionable delays; altering established treatment regimens; failing to provide necessary mental health services; overuse of solitary confinement; and ignoring repeated requests for care from detainees with serious symptoms. *Id.* ¶¶ 23-36. These deficiencies in medical treatment have placed individuals at risk of strokes, heart attacks, renal failure, amputation, life-threatening heart conditions, kidney failure, and blindness. *Id.* ¶¶ 41-44. Last year, a mumps outbreak at Bergen County Jail resulted in the quarantine of dozens of immigration detainees for several weeks.

38. The Department of Homeland Security's own Office of the Inspector General also recently reported on the substandard care, long waits for medical care and hygiene products, and mistreatment in ICE detention facilities.

The COVID-19 Pandemic Presents a Grave Risk of Harm, Including Serious Illness and Death to Those with Certain Medical Conditions.

39. COVID-19 can lead to severe illness, extended hospitalization, and death. Greifinger Decl. ¶¶ 5-6. Older patients and those with chronic underlying conditions are at a particularly high risk for severe cases and complications. *Id.* ¶¶ 5-7. Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age "include blood disorders, kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy." *Id.* ¶ 7.

40. According to preliminary data from China, 20% of high-risk individuals who contract COVID-19 have died. *Id.* ¶ 5.

41. Those in high-risk categories who do not die may have prolonged serious illness requiring hospital care, including ventilators that will likely be in very short supply. *Id.* ¶ 6.

Plaintiffs Are Medically-Vulnerable Individuals Who Face a Heightened Risk of Severe Harm if They Contract COVID-19 While Detained.

42. Plaintiffs in this case face unprecedented and imminent harm because COVID-19 has already started to spread in their jails. Each plaintiff has one or more underlying medical conditions that renders him particularly vulnerable to severe illness or death if he contracts the disease.

43. **Cristian Arriaga Reyes.** Mr. Arriaga is a 33-year-old man who has been incarcerated by ICE at the Hudson County Jail since January 2020. He is a long time New Yorker with strong community support in Queens. If released, he will live with his brother in Flushing and receive the support of his sisters, with whom he is very close. Mr. Arriaga's sole criminal conviction is a 2018 conviction for attempted endangering the welfare of a child, for which he received a sentence of a one-year conditional discharge.

44. Mr. Arriaga suffers from type 2 diabetes and hypertension and has been prescribed daily medication and insulin shots for his condition. In the last two months, Mr. Arriaga's blood sugar levels have been well above the medically recommended range. Additionally, jail staff have refused to give Mr. Arriaga Advil for his arthritis.

45. Because of his medical conditions, Mr. Arriaga is at high risk for severe illness or death if he contracts COVID-19. Based on these conditions, The Legal Aid Society filed a written request for release with ICE on March 19, 2020, describing Mr. Arriaga's equities, severe medical conditions, and the risks he faces if he contracts COVID-19 in jail. ICE has not responded to his request.

46. **Fedor Bondarenko.** Mr. Bondarenko is a 35-year-old man who ICE has incarcerated since December 2019 at Bergen County Jail. Fearing persecution in his home country of Russia, Mr. Bondarenko applied for asylum shortly after entering the United States. He has no criminal convictions and no criminal record at all in the United States.

47. Mr. Bondarenko suffers from asthma, high blood pressure, chronic hepatitis B, acute prostatitis (deep infection of the prostate), and post-operative complications of hemorrhoid surgery. Mr. Bondarenko experiences constant pain, intermittent bleeding due to hemorrhoids, and frequent urination.

48. Prior to his immigration hearing on March 19, 2020, Mr. Bondarenko, through his Bronx Defenders' attorney, filed a motion for changed circumstances on bond based on ineffective assistance of his prior counsel and new evidence regarding his lack of flight risk, worsening health, and risks of COVID-19 infection. However, the Immigration Judge refused to even hear him on that motion as she stated she had not received the hard copy in her file; she further

refused to accept the courtesy copy of the motion that had been emailed to her and instead adjourned Mr. Bondarenko's case to April 16, 2020.

49. Because of his medical co-morbidities, Mr. Bondarenko is at high risk of severe illness or death if he contracts COVID-19. Based on these conditions, The Bronx Defenders filed a written request for release with ICE on March 13, 2020, and sent updated medical information on March 31, describing his equities, severe medical conditions, and the risks he faces if he contracts COVID-19 in jail. ICE has not responded to his request.

50. **Santiago Cabrera Campoverde.** Mr. Cabrera is a 36-year-old man who ICE has incarcerated at Bergen County Jail since January 2020. He has lived in the United States since 2005, during which time he has worked consistently. Mr. Cabrera has multiple U.S. citizen and lawful permanent resident family members in the New York area with whom he is close, as well as a 16-year-old daughter whom he supports. His first wife passed away from cancer in 2010 and he is his daughter's only living parent. He will return to living in Brooklyn, where he resided prior to his detention, if released.

51. Mr. Cabrera suffers from hypertension, for which he takes medication, and kidney stones, for which he requires surgery. Mr. Cabrera was taken to an external clinic this month while in ICE custody as a result of intense stomach pain and was diagnosed with kidney stones. The physician prescribed him pain medication and recommended that he receive surgery for the kidney stones. Mr. Cabrera also is receiving daily medication for his high blood pressure; he has had a history of hypertension for the past six years.

52. In the 15 years he has resided in the U.S., Mr. Cabrera has been arrested on two occasions, resulting in a single conviction. The first arrest, in 2013, resulted in a conviction for driving while ability impaired under New York Vehicle and Traffic Law ("VTL") § 1192.1, an

infraction under New York law. The second arrest, in September 2019, involved a top charge of misdemeanor assault in the third degree for events that allegedly occurred in July and August 2019; all those charges were fully dismissed in January 2020.

53. Because of his medical conditions Mr. Cabrera is at high risk for severe illness or death if he contracts COVID-19. Based on these conditions, The Bronx Defenders filed a written request for release with ICE on March 29, 2020, describing Mr. Cabrera's equities, severe medical conditions, and the risks he faces if he contracts COVID-19 in jail. ICE has not responded to his request.

54. **Noe Cornejo Melende**. Noe Cornejo Melende is a 40-year old long-time New Yorker who has been detained in ICE custody since August 2019. He is being held at the Bergen County Jail. He has lived in the New York area for about 16 years and has strong family ties in this country, including a U.S. citizen wife and four U.S. citizen stepchildren who he is helping to raise. If released, Mr. Cornejo Melende would live with his stepson in Westbury, New York. His wife and younger stepchildren, who were forced to relocate to Texas while Mr. Cornejo has been detained so that his in-laws could assist with childcare, will also return to Westbury and live with them.

55. Mr. Cornejo has a criminal conviction stemming from an arrest in 2017 for driving while intoxicated under VTL § 1192.2 and for driving without a license under Vehicle and Traffic Law § 509.1. He has a second conviction stemming from an arrest in 2019 for aggravated driving while intoxicated under Vehicle and Traffic Law § 1192.2a and aggravated unlicensed operation of a motor vehicle under Vehicle and Traffic Law § 511.3. Mr. Cornejo served a custodial sentence for the second case, for a term of four months. He also has an earlier disorderly conduct conviction from 2014 under New York Penal Law § 240.20.

56. Mr. Cornejo Melende was recently diagnosed with Bell's Palsy and has been prescribed Prednisone for his condition. Prednisone is an oral steroid, which suppresses his immune systems. Because of his immune system is suppressed, and because of his underlying neurological condition, he is at high risk for severe illness or death if he contracts COVID-19. Based on these conditions, The Legal Aid Society filed a written request for release with ICE on April 1, 2020, describing Mr. Conejo's equities, severe medical conditions, and the risks he faces if he contracts COVID-19 in jail. ICE has not responded to his request.

57. **Alvaro Negrette Mejia.** Mr. Negrette is a 59-year-old lawful permanent resident of the United States who has lived in the United States for over three decades. He has been detained in ICE custody at the Hudson County Jail since March 2019. Mr. Negrette has strong family ties in the country, including a U.S. citizen daughter and three U.S. citizen grandchildren. He was also a critical source of support and care to his ailing elderly mother, who passed away in 2019 while he was in ICE custody.

58. Stemming from a single case in 1992, Mr. Negrette has convictions for sexual abuse and endangering the welfare of a child. He also has 2002 and 2007 convictions for failure to register as a sex offender and two convictions from the 1980s for driving while intoxicated and driving while ability impaired, respectively. Mr. Negrette has not had any criminal contacts in over a decade, has not served a custodial sentence since his release in 1997, and has demonstrated significant rehabilitation including maintaining a loving relationship with his children and grandchildren and caring for his ailing mother. Mr. Negrette suffered a heart attack approximately five years ago, and he has type 2 diabetes, hypertension, and high cholesterol. Because of the lockdown at Hudson, Mr. Negrette reports that he is not receiving his insulin at the same time every day, which has complicated his ability to manage his medical conditions.

59. Because of his medical conditions, Mr. Negrette is at high risk for severe illness or death if he contracts COVID-19. Based on these conditions, The Legal Aid Society filed a written request for release with ICE on March 23, 2020, describing Mr. Negrette's equities, severe medical conditions, and the risks he faces if he contracts COVID-19 in jail. ICE has not responded to his request.

ICE was on Notice of the Risks of COVID-19 to Medically Vulnerable Detainees.

60. Because each of the individual plaintiffs in this case brought their medical conditions to ICE's attention, the Defendants had actual knowledge of their high-risk of harm from contracting COVID-19.

61. Defendants have also long been on notice of the risk that COVID-19 poses generally to persons with certain underlying medical conditions. Indeed, medical experts who contracted with the DHS Office of Civil Rights and Civil Liberties raised concerns to the Department in February and March 2020.[1] On March 19, 2020, they brought their concerns to the House and Senate Committees on Homeland Security. Allen & Rich Letter at 2. They explained that in order to save both the lives of detainees and in the community at large, "minimally, DHS should consider releasing all detainees in high risk medical groups[.]" *Id*. at 5-6.

62. John Sandweg, a former acting director of ICE, has written publicly about the need to release nonviolent detainees because ICE detention centers "are extremely susceptible to outbreaks of

[1] *See* March 19, 2020 letter from Scott A. Allen, MD, FACP and Josiah Rich, MD, MPH to House and Senate Committees on Homeland Security, *available at* https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf [Hereinafter "Allen & Rich Letter"].

infectious diseases" and "preventing the virus from being introduced into these facilities is impossible."[2]

63. Moreover, advocates put Defendants on notice of the risks posed to individuals in New Jersey on March 20, 2020.

No Other Forum, Including ICE and Immigration Courts, Can Provide Meaningful Relief to Abate the Harm to Plaintiffs.

64. ICE has the authority to release individuals like Plaintiffs, whose detention is governed by the discretionary detention statute, 8 U.S.C. § 1226(a). Despite the exigent circumstances, ICE continues to improperly deny release or bond to plaintiffs, whose equities and minimal or temporally-distant criminal histories demonstrate that they are neither dangers to the community nor risks of flight.

65. ICE has a range of highly effective tools at its disposal to ensure that individuals report for court hearings and other appointments, including conditions of supervision while released. For example, ICE's conditional supervision program, called Intensive Supervision Appearance Program ("ISAP"), relies on the use of electronic ankle monitors, biometric voice recognition software, unannounced home visits, employer verification, and in-person reporting to supervise participants. A government-contracted evaluation of this program reported a 99% attendance rate at all immigration court hearings and a 95% attendance rate at final hearings.

66. Counsel for Plaintiffs, The Legal Aid Society ("LAS") and The Bronx Defenders ("BXD"), routinely liaise with ICE officials and with counterparts at the U.S. Attorney's Office to secure the release of clients with severe medical conditions or other compelling circumstances on

[2] *See* John Sandweg, "I Used to Run ICE. We Need to Release the Nonviolent Detainees." *The Atlantic* (March 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/release-ice-detainees/608536/ (Ex. T to Haas Decl.).

conditions or reasonable bond. Consistent with this practice, both LAS and BXD reached out to the government to identify high-risk clients, including Plaintiffs.

67. Under normal circumstances, individuals like Plaintiffs would be able to seek either initial or changed-circumstances bond hearings in the immigration courts. At such hearings, agency precedent requires the individuals to bear the burden of proving they are not a danger nor a flight risk in order to win release on bond.

68. Under this system, each of these Plaintiffs is detained, at high risk of severe illness or death, without the government ever having had to justify the need for their detention to any neutral adjudicator. And without this Court's intervention, the government will never have to make any showing to justify its detention decisions.

69. Making matters worse, the COVID-19 pandemic has caused the Varick Immigration Court, in New York City, where the Plaintiffs' removal proceedings are venued, to no longer provide an effective forum for them to vindicate their right to have their custody reviewed. This is true for a number of reasons: detainees can no longer consistently or privately communicate with their counsel; the Immigration Court is incapable of providing effective and adequate mechanisms for remote appearances by attorneys; detainees, their family members, and counsel can no longer collect the required evidence and documentation to meet their burden of proof in bond hearings given the closure of most public and private institutions and restrictions on movement; and finally, because it has become increasingly difficult to post bond even should an immigration judge set bond due to several bond office closures.

70. First, both facilities at which Plaintiffs are detained ended contact visits for legal visitation due to COVID-19. However, because there is no other effective, reliable, and confidential manner

to communicate with clients, the end of contact visits has rendered it prohibitively difficult to have the in-depth private conversations required for representation in bond or other matters.

71. While Hudson County Correctional Facility has video teleconference systems that attorneys can use to speak to detainees, the system is plagued by technological problems including poor quality of video and audio, frequent malfunctions, and a lack of privacy at the jail. Since the onset of the pandemic, attorneys have been forced to use the video systems with much greater frequency, but the systems have not expanded capacity. As a result, scheduled appointments have been canceled, no additional time slots have been made available, and audio and video quality has deteriorated further. As such, this method of communicating with plaintiffs is inadequate.

72. Bergen County Jail lacks remotely-accessible video teleconference systems. The ability of attorneys to request legal phone calls with their clients that are free, confidential, or easily accessible has fluctuated in the past three weeks, with some calls being completed successfully while other requests for phone calls going unanswered.

73. Second, the Varick Immigration Court has not formulated policies or implemented mechanisms that allow attorneys to adequately represent their clients in the context of this public health crisis. Normally, attorneys appear in person from court, even as their clients appear either by video teleconference or in person. Now, however, as officials at every level of government have issued instructions to avoid contact and stay at home to the greatest extent possible, attorneys are frequently seeking to appear by telephone and find effective mechanisms of service of documents to the Immigration Court.

74. A number of attorneys have filed urgent requests for bond hearings to be scheduled on behalf of their clients in the past three weeks but many have been unable to obtain responses from

court staff, or been scheduled for hearings within weeks or longer instead of within days as requested.

75. On Monday, March 23, 2020, the Department of Justice announced that the Varick Immigration Court would be closed the following day after a court staffer was confirmed positive for COVID-19. On the same day, the National Association of Immigration Judges said that a judge at Varick had been diagnosed with pneumonia and was tested for COVID-19.

76. On Thursday, March 26, the Varick Immigration Court announced a new policy that is likely to significantly worsen existing problems. In an email to several legal service providers, a court administrator announced that until April 10, all Varick Immigration Court cases will be heard by judges located at the Fort Worth Immigration Adjudication Center in Fort Worth, Texas.

77. This change causes many concerns including the ability of attorneys to timely receive and review evidence filed by the government and the likelihood of evidence filed on behalf of detainees timely reaching the center in Fort Worth.

78. On Friday, March 27, the first day that the Fort Worth judges were supposed to preside over Varick Immigration Court cases, several attorneys who were scheduled to go forward that day were never called by the Court. On Monday, March 30, the second day, some attorneys were called for their clients' hearings but cases could not practically move forward due to issues with the receipt and submission of evidence. Attorneys also reported problems hearing everything happening in the courtroom during hearings given the multiple connections involved. And judges from other parts of the country are reportedly hearing Varick Immigration Court cases this coming week.

79. Third, due to widespread closure of government offices and private businesses, and the directives for individuals to stay at home to the greatest extent possible, it has become

prohibitively difficult for detainees to meet their burden of proof in bond hearings. Courts in New York recently closed except for non-essential functions, and have stopped producing certificates of disposition or copies of court files in a timely manner in response to records requests. However, immigration judges routinely draw adverse inferences and deny bond when individuals fail to produce documentary evidence, such as criminal court documents, police reports, hospital and school records, to support their applications for bond. Making such a showing is nearly impossible under the present circumstances.

80. Finally, the only facility in New York City where immigration bonds can be posted has been closed for several days, requiring people to travel to the bond office in Newark, New Jersey.

CAUSES OF ACTION

FIRST CLAIM
Violation of the Right to Substantive Due Process

81. Defendants' conduct violates Plaintiffs' right to substantive due process under the Fifth Amendment of the United States Constitution.

82. Defendants' conduct violates Plaintiffs' right to procedural due process under the Fourteenth Amendment of the United States Constitution.

SECOND CLAIM
Violation of the Right to Procedural Due Process

83. Defendants' conduct violations Plaintiffs' right to procedural due process under the Fifth Amendment of the United States Constitution.

84. Defendants' conduct violates Plaintiffs' right to procedural due process under the Fourteenth Amendment of the United States Constitution.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs prays that this Court grant the following relief:

1) Assume jurisdiction over this matter;
2) Issue a Writ of Habeas Corpus on the ground that Plaintiffs' continued detention violates the Due Process Clause, and order Plaintiffs' immediate release, with appropriate conditions as necessary;
3) In the alternative, issue injunctive relief ordering Defendants to immediately release Plaintiffs, with appropriate conditions as necessary, on the grounds that their continued detention violates Plaintiffs' due process rights;
4) In the alternative, issue an order requiring Defendants to provide Plaintiffs with constitutionally adequate, individualized hearings within 48 hours at which the Department of Homeland Security bears the burden of establishing by clear and convincing evidence that continued detention is justified in light of the grave risks to Plaintiffs' health and well-being in ICE custody, at which Plaintiff's vulnerability to COVID-19 is weighed as a factor favoring release; and at which the detainee's ability to pay and alternative conditions of release are considered; or to immediately release Plaintiffs if such a bond hearing does not occur as specified;
5) Issue a declaration that Defendants' continued detention of Plaintiffs, who are at increased risk for severe illness from COVID-19, violates the Due Process Clause;
6) Award reasonable attorneys' fees and costs for this action;
7) Grant any other and further relief that this Court deems just and proper.

Dated: April 6, 2020
New York, NY

Respectfully submitted,

/s/ Katherine Haas

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**Petition for permission to file pro hac vice forthcoming*
***Petition for permission to file pro hac vice forthcoming; not admitted in D.C.; practice limited to federal court.*

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

COVID-19

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of April 4, 2020, according to the World Health Organization, 1,051,653 people have been diagnosed with COVID-19 around the world and 56,985 have died. In the United States, 241,703 people have been diagnosed and 5,854 people have died thus far.[2] These numbers are likely an underestimate, due to the lack of availability of testing.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti- viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

5. People in the high-risk category for COVID-19, i.e., adults 65 years old and older or those

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[1] Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. Journal of Correctional Health Care OnlineFirst, published on May 12, 2010 as doi:10.1177/1078345810367593.

[2] World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-75, Apr. 4, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200404-sitrep-75-covid-19.pdf?sfvrsn=99251b2b_2.

with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.

7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, 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.

The Risks of COVID-19 in Immigration Detention

9. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

10. Immigration detention facilities are enclosed environments, much like the cruise ships and nursing homes that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

11. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, 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.

Bergen County Jail, Hudson County Correctional Facility, and ICE Have Failed to Adequately Respond to the COVID-19 Pandemic.

12. Bergen County Jail and Hudson County Correctional Facility are not able to prevent the spread of COVID-19 or to provide adequate care to people detained in the facilities who

experience serious symptoms or complications of COVID-19.

13. On March 24, 2020, ICE reported that a detainee at the Bergen County Jail had tested positive for COVID-19, following reports that a guard at the same facility had tested positive for COVID-19. According to reports from ICE, at least two people detained by ICE at Hudson County Correctional Facility have tested positive for COVID-19, one correctional officer at Hudson has died of COVID-19, and at least two people detained by ICE at Bergen County Jail has tested positive for COVID-19.[3] These confirmed cases, along with the general lack of access to testing for ICE detainees, indicates an imminent risk of COVID-19 transmission in these facilities.

14. Upon information and belief, detainees in Bergen County Jail and Hudson County Correctional Facility are confined in close quarters and continue to share resources like toilets and sinks. They are unable to practice social distancing in their cells. Hudson's protocol of allowing detainees to leave their cells in two shifts numbering over a hundred people at once makes social distancing outside of their cells impossible, as well.

15. Detainees report a lack of soap and other essential hygiene supplies, preventing them from practicing proper hygiene that is essential to preventing further spread of COVID-19.

16. On information and belief, Bergen County Correctional Facility is confining detainees to cells for 23.5 hours per day. This can lead to extreme psychological stress and, as discussed below, can lead to severe anxiety, psychological deterioration, and self-harm.

17. Isolation is not a proper solution for people without symptoms or confirmed disease. This includes isolated confinement with a cellmate. Detainees who are isolated are monitored less frequently. If they develop COVID-19 symptoms, or their symptoms escalate, they may not be able to get the medical attention they desperately need in a timely fashion. Isolation also makes it more likely that these detained people will attempt suicide or self-harm, giving rise to more medical problems in the midst of a pandemic. Isolation also increases the amount of physical contact between staff and detained people—in the form of increased handcuffing, escorting individuals to and from the showers, and increased use of force due to the increased psychological stress of isolation. My expert opinion is that the use of isolation or lockdown is not a medically appropriate method for abating the substantial risks of COVID-19.

18. Upon information and belief, the Bergen County Correctional Facility has created a "COVID Dorm," where people with suspected cases of COVID cohorted, i.e., they are housed together. The Centers for Disease Control and Prevention (CDC) identifies "cohorting" as a suboptimal practice for infected patients. Where cohorting can be an effective mitigation strategy in the absence of sufficient space for medical isolation, it requires adequate space for appropriate groupings. For instance, confirmed cases should not be in the same cohort as suspected cases or case contacts; those who had contact with an

[3] *See* "ICE Guidance on COVID-19: Confirmed Cases," U.S. Immigration and Customs Enforcement (Apr. 4, 2020), *available at* https://www.ice.gov/coronavirus; Rodrigo Torrejon, *Hudson County Jail Correctional Officer, 56, Dies from Coronavirus, Police Union Says*, NJ.com, Apr. 2, 2020, https://www.nj.com/coronavirus/2020/04/hudson-county-jail-correctional-officer-56-dies-from-coronavirus.html.

infected person ten days ago should not be in the same cohort as someone who had contact with an infected person two days ago. Yet this is likely impossible based upon the staffing and space constraints inherent in ICE detention.

19. In these facilities and others, ICE has failed to adequately respond to the COVID-19 pandemic. ICE's guidance on its website[4] is wholly insufficient to adequately face the crisis at hand.

20. Transferring individuals between facilities, a common ICE practice, is medically inappropriate during the outbreak. ICE does not have the staffing needed to monitor the transferred patients for the appropriate 14-day period to check for symptoms.

Release is Necessary to Prevent Serious Harm.

21. ICE must release all people with risk factors to prevent serious illness including death. ICE's response has made abundantly clear that they do not plan to establish special protections for high-risk patients, instead waiting for them to become symptomatic. This will lead to unnecessary illness and death for the people most vulnerable to this disease. ICE is walking willingly into a preventable disaster by keeping high-risk and vulnerable patients in detention facilities during the rapid spread of COVID-19.

22. 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 high-risk individuals is a key part of a risk mitigation strategy. As staff come and go daily from ICE detention centers, this facilitates transmission of the disease from the facility to staff's families and thereby to their communities. 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.

23. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. Release also reduces 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.

24. 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. Those who test positive should be released to quarantine, with conditions consistent with recommendations of the local health department.

25. This release cohort can be separated into two groups. Group 1 could be released to home

[4] U.S. Immigration and Customs Enforcement, *ICE Guidance on COVID-19*, ICE.gov (last reviewed/updated Apr. 3, 2020), https://www.ice.gov/covid19.

quarantine for 14 days, assuming they can be picked up from detention by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with local or state public health authorities.

Plaintiffs Are at Risk for Serious Illness and Death from COVID-19

26. I have reviewed the factual claims of Plaintiffs' medical conditions made in Plaintiffs' complaint. On the basis of the claims presented, I conclude that plaintiffs in this lawsuit present with personal health characteristics that put them at high risk for complications from COVID-19 should they be exposed to the virus in detention.

    a. Upon information and belief, Cristian Arriaga Reyes has been diagnosed with Type 2 diabetes and hypertension. As a result, he is at higher risk for complications from COVID-19 due to these medical conditions. According to the CDC and the American Diabetes Association, those with diabetes are at a higher risk for COVID-19 complications, but also to deadly conditions resulting from the viral infection itself overwhelming the body, such as diabetic ketoacidosis. Further, early research has shown that those with a diagnosis of hypertension have more severe symptoms and are more likely to die from COVID-19. Mr. Reyes is therefore at a very high risk of severe complications or death from COVID-19.

    b. Upon information and belief, Fedor Bondarenko has been diagnosed with asthma, high blood pressure, chronic hepatitis B, acute prostatitis, and post-operative complications of hemorrhoid surgery. As a result of these medical conditions, he is therefore at a very high risk of severe complications or death from COVID-19.

    c. Upon information and belief, Santiago Cabrera Campoverde has been diagnosed with hypertension and kidney stones, for which he requires surgery. As stated above, early research has shown that those with a diagnosis of hypertension suffer more severe symptoms and are more likely to die from COVID-19. Mr. Campoverde is is therefore at a very high risk of severe complications or death from COVID-19.

    d. Upon information and belief, Noe Cornejo Melende was recently diagnosed with Bell's palsy, for which he has been prescribed Prednisone. Prednisone is a corticosteroid that works by suppressing the body's immune system to decrease inflammation. People taking immunosuppressing medications appear to be at elevated risk of severe illness or death from COVID-19. Mr. Cornejo Melende is is therefore at a very high risk of severe complications or death from COVID-19.

    e. Upon information and belief, Alvaro Negrette Mejia is a 59-year-old man who suffers from type 2 diabetes, hypertension, and high cholesterol. He suffered a heart attack in the past and he has not been receiving his insulin at the same time every day, making it difficult to manage his diabetes. As explained above, early research has revealed that people with diabetes and hypertension are more likely to experience serious complications or death from COVID-19.

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

Executed this _*5th*_ day in April 2020 in New York City, New York.

Robert B. Greifinger, M.D.

ROBERT B. GREIFINGER, M.D.

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Physician consultant with extensive experience in development and management of complex community and institutional health care programs. Demonstrated strength in leadership, program development, negotiation, communication, operations and the bridging of clinical and public policy interests. Teacher of health and criminal justice.

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

Consultant on the design, management, operations, quality improvement, and utilization management for correctional health care systems.

- Recent clients include (among others) the U.S. Department of Justice Civil Rights Division, monitoring multiple correctional systems and the U.S. Department of Homeland Security Office of Civil Rights and Civil Liberties. Federal court monitor for the Metropolitan Detention Center, Albuquerque, New Mexico, Orleans Parish Sheriff's Office, New Orleans, Louisiana, and Miami-Dade Corrections and Rehabilitation Department.
- National Commission on Correctional Health Care. Principal Investigator for an NIJ funded project to make recommendations to Congress on identifying public health opportunities in soon-to-be-released inmates.
- Associate Editor, Puisis M (ed), Clinical Practice in Correctional Medicine, Second Edition, St. Louis. Mosby 2006.
- Editor, Greifinger, RB (ed), Public Health Behind Bars: From Prisons to Communities, New York. Springer 2007.
- John Jay College of Criminal Justice. Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow 2005 – 2016.
- Co-Editor, International Journal of Prison Health 2010 – 2016.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

Operating budget of $1.4 Billion. Responsible for inmate safety, program, and security. Sixty-nine facilities housing over 68,000 inmates with 30,000 employees.

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

- Operating budget of $140 million; health services staff of 1,100. Accountable for inmate health services and public health. Directed major initiatives in policy and program development, quality and utilization management.
- Developed and implemented comprehensive program for HIV prevention, surveillance, education, and treatment in nation's largest AIDS medical practice.
- Managed the rapid implementation of an infection control program responding to a major outbreak of multidrug-resistant tuberculosis. Helped bring the nation's tuberculosis epidemic to public attention.
- Developed $360 million five-year capital plan for inmate health services. Opened the first of five regional medical units for multispecialty ambulatory and long-term care.
- Implemented a centralized and regional pharmacy system, improving quality, service and cost management.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1985 - 1989

A major academic medical center with 8,000 employees and annual revenue of $500 million.

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

Operating budget of $60 million with 1,100 employees. Managed a multi-specialty group, a home health agency, and prison health programs.

- Negotiated contracts, including bundled service, risk capitation, fee-for-service arrangements, and major service contracts. Developed a high technology home care joint venture.
- Taught epidemiology and health care organization at Albert Einstein College of Medicine. Lectured nationally on health care delivery and managed care.
- Conceived and collaborated in development of a consortium of six academic medical centers, leading to a metropolitan area-wide, joint venture HMO. Organized a network of physicians to contract with HMO's preparing for cost-containment.

WESTCHESTER COMMUNITY HEALTH PLAN, White Plains, NY 1980 - 1985

Independent, not-for-profit, staff-model HMO, acquired by Kaiser-Permanente in 1985. Operating revenue $17 million with 200 employees and 27,000 members.

Vice President and Medical Director

Chief medical officer and COO. Managed the delivery of comprehensive medical services. Accountable to the Board of Directors for quality assurance and utilization management. Practiced pediatrics.

- Accomplished turnaround with automated utilization management, improved service, sound personnel management principles, and quality management programs.
- Implemented performance based compensation program.

COMMUNITY HEALTH PLAN OF SUFFOLK, INC. 1977 - 1980

Community based, not-for-profit, staff model HMO, with enrollment of 18,000.

Medical Director

- Developed and operated clinical services. Accountable for quality of care. Practiced clinical pediatrics, and taught community health and medical ethics at SUNY Stony Brook School of Medicine.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1976 - 1977

Residency Program in Social Medicine, Deputy Director, 1976-1977

Unique clinical training program focused on community health and change agentry. Developed curriculum and supervised 40 residents in internal medicine, pediatrics and family medicine.

UNITED STATES PUBLIC HEALTH SERVICE 1972 - 1974

Commissioned officer in the National Health Service Corps. Functioned as medical director and family physician in a federally funded neighborhood health center in Rock Island, Illinois. Honorable Discharge.

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

1976 - 2002
Assistant Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine

2005 - 2016
Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow, John Jay College of Criminal Justice

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Worked with NCQA since its inception in 1980. Began training surveyors in 1989, and continued as faculty for NCQA sponsored educational sessions. Served for six years as a charter member of the Review Oversight (accreditation) Committee. Served on the Reconsideration (appeals) Committee for six years. Surveyed dozens of managed care organizations, and reviewed several hundred quality management programs.

OTHER PROFESSIONAL ACTIVITIES

2012 – present	Member, Board of Directors, Prison Legal Services, New York
2012 – present	Member, Board of Directors, National Health Law Program
2011 – 2015	Member, Board of Directors, Academic Consortium of Criminal Justice Health
2010 - 2016	Co-editor, International Journal of Prisoner Health
2009	Recipient, B. Jaye Anno Award for Lifetime Achievement in Communication
2007-2015	Member, National Advisory Group on Academic Correctional Health Care
2007	Recipient, Armond Start Award, Society of Correctional Physicians
2005 - 2011	Member, Advisory Board to the Prisoner Reentry Institute, John Jay College
2002 - present	Member, Editorial Board, Journal of Correctional Health Care
2002 - present	Peer reviewer for multiple journals, including Journal of Correctional Health Care, International Journal of Prison Health, Journal of Urban Health, Journal of Public Health Policy, Annals of Internal Medicine, American Journal of Public Health, Health Affairs, and American Journal of Drug and Alcohol Abuse.
2001 - 2003	Member, Advisory Board to CDC on Prevention of Viral Hepatitis in Correctional Facilities
1999 - 2003	Member, Advisory Board to CDC on Prevention and Control of Tuberculosis in Jails
1997 - 2003	Member, Reconsideration Committee, NCQA
1997 - 2001	Moderator, Optimal Management of HIV in Correctional Systems, World Health Communications
1997 - 2000	Member, Reproductive Health Guidelines Task Force, CDC
1993 - 1995	Co-chair, AIDS Clinical Trial Community Advisory Board, Albany Medical Center
1992 - Present	Society of Correctional Physicians
1991 - 1997	Member, Review Oversight (accreditation) Committee, NCQA

1983 - 1985 Executive Committee, Medical Directors' Division, Group Health Association of America (Secretary, 1984-1985)

EDUCATION

University of Pennsylvania, College of Arts and Sciences, Philadelphia; B.A., 1967 (Amer. Civilization)

University of Maryland, School of Medicine, Baltimore; M.D., 1971

Residency Program in Social Medicine (Pediatrics), Montefiore Medical Center, Bronx, NY; 1971-1972, 1974-1976, Chief Resident 1975-1976

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

Fellow, American College of Correctional Physicians (formerly Society of Correctional Physicians), 2000

License: New York, Pennsylvania (inactive)

ROBERT B. GREIFINGER, M.D.

Updated February 2018

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JOSE L. VELESACA, on his own behalf and on behalf of others similarly situated, Petitioners-Plaintiffs, v. THOMAS R. DECKER, in his official capacity as New York Field Office Director for U.S. Immigration and Customs Enforcement; MATTHEW ALBENCE, in his official capacity as the Acting Director for U.S. Immigration and Customs Enforcement; UNITED STATES IMMIGRATION AND CUSTOMS ENFORCEMENT; CHAD WOLF, in his official capacity as Acting Secretary of the U.S. Department of Homeland Security; UNITED STATES DEPARTMENT OF HOMELAND SECURITY; and CARL E. DUBOIS, in his official capacity as the Sheriff of Orange County and the official in charge of the Orange County Jail, Respondents-Defendants.	Case No. 1:20-cv-1803

DECLARATION OF MARINDA VAN DALEN

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

1. I am Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI). I have held this position since 2017 and contribute to the strategic direction of the program in a leadership role. I lead NYLPI's Health in Immigration Detention litigation program and contribute in a leadership role to our multi-pronged program assessing and seeking to improve access to healthcare in immigration detention facilities in the New York City area. We launched this program in May 2015.

Background on New York Lawyers for the Public Interest Health Justice Program:

2. Founded over 40 years ago, NYLPI pursues equality and justice for all New Yorkers. NYLPI's community-driven approach powers its work in the areas of civil rights and health, disability, immigrant, and environmental justice. NYLPI seeks lasting change

through legal representation and litigation, community organizing, policy advocacy, pro bono service, public education. NYLPI's Health Justice Program works to bring a racial justice and immigrant rights focus to health care advocacy in New York City and New York State. We work to: (1) challenge health disparities; (2) eliminate racial and ethnic discrimination and systemic and institutional barriers that limit universal access to health care; (3) promote immigrant and language access to health care, including representing undocumented and uninsured immigrants and people confined to immigration detention who have serious health care needs; and (4) address the social determinants of health so that all New Yorkers can live a healthy life.

3. NYLPI has a long commitment to immigrant justice and the challenges faced by immigrant communities, with work ranging from individual representation to statewide advocacy campaigns focused on access to healthcare. In 2000, NYLPI launched campaigns to improve immigrant access to health care, with a focus on the lack of language access and culturally appropriate services for immigrants. Years of individual and systemic advocacy led to State regulations in 2006 that require all private and public hospitals in New York State to provide skilled interpreters, translate important hospital forms into commonly used languages, and ensure that non-English speaking patients do not experience excessive delays because of language issues. In 2009 New York City Mayor Michael Bloomberg signed the Language Access in Pharmacies Act, drafted by NYLPI, requiring City pharmacy chains to provide translation and interpretation services, and in 2012 New York Governor Andrew Cuomo signed parallel legislation known as SafeRx, instituting the same requirements for State pharmacy and mail-order chains. In 2011 NYLPI helped lead a coalition to press the Governor to issue Executive Order 26, a statewide language access policy requiring state agencies that interact directly with the public to translate vital public documents into the most common non-English languages and provide interpretation services. NYLPI continues to monitor compliance with all of this legislation, and in 2017 secured a landmark settlement in a class action ensuring equal access for 10,000 Limited English Proficient people with disabilities who were excluded from the New York City Access-A-Ride paratransit system because it failed to provide translation and interpretation services. NYLPI is also long-standing co-counsel on *Brad H. v. City of New York*, which established the right to medical discharge planning for individuals with mental illness at Rikers Island.

4. After receiving numerous complaints from community members, immigration legal service providers, and advocates, NYLPI launched a project in May 2015 to document conditions in immigration detention and assist seriously ill immigrants in obtaining necessary medical care while detained. We interviewed advocates and affected individuals across the country to learn of patterns of harm. We uncovered a great need for focus on the conditions of confinement, and specifically access to healthcare.

5. NYLPI is a leader in the New York City area on these issues. Our work focuses on people who are detained while they are in removal proceedings and whose cases are placed at Varick Street Immigration Court.

6. We operate a volunteer network of approximately 95 medical providers (NYLPI Medical Provider Network or MPN) who advocate along with lawyers on behalf of immigrants in detention who have serious medical conditions. The network seeks to improve, among other things, the care detention centers provide and gain the release of those with unmet medical needs. The medical providers volunteering with our medical-legal-community partnership have specialties such as neurology, psychiatry, endocrinology, cardiology, obstetrics, gynecology, mental health, and family medicine. We regularly present to and train doctors, residents, and nurses across New York City, including at Bellevue Hospital, the New York City Refugees and Asylees Health Coalition, Columbia Medical Center, Montefiore Human Rights and Social Justice Residents Group, and to nursing students at SUNY Downstate. We provide support for New York Immigrant Family Unity Project (NYIFUP) attorneys and community-based organizations whose clients lack adequate medical care.

7. NYLPI also litigates civil rights cases challenging the denial of appropriate medical care. We served as lead counsel in *Charles v. Orange County* and *Charles v. United States,* two lawsuits challenging the failure of Orange County Detention Center and ICE to provide mental health discharge planning to two individuals with serious mental health conditions discharged from detention and dumped on the streets. In *Charles v. Orange County*, in May 2019, the U.S. Court of Appeals for the Second Circuit affirmed the right to mental health discharge planning under the constitution and confirmed the legal standard for a constitutional violation in immigration detention as deliberate indifference to serious medical needs. We brought claims against the U.S. under the Federal Tort Claims Act, and the district court's decision in that case sets persuasive precedent to implicate ICE in medical care breaches experienced by people in detention. Both cases subsequently settled for substantial sums for our clients.

8. NYLPI is also litigating two additional cases against Hudson County Detention Center, the contracted medical provider at the time the individuals suffered harm in detention, and individuals responsible for providing their medical care while they were confined. We brought one case on behalf of the family of an individual maltreated in detention who hemorrhaged to death within only a couple of months of being detained, and another on behalf of a person who experienced permanent health damage after approximately a year and a half in detention, deprived of the medical care he needed. Through each of these cases, NYLPI gathers additional information about conditions in detention and the

processes of providing -- or failing to provide -- healthcare to people in immigration detention.

9. Since our Healthcare in Immigrant Detention Project's founding in 2015, we have interviewed, advocated for, and/or received requests for medical provider referrals for nearly 150 people confined to immigration detention facilities in the New York-area. These individuals were detained at Hudson County Correctional Facility, Bergen County Jail, Essex County Correctional Facility, Elizabeth Detention Center, and Orange County Correctional Facility. From time to time we receive requests from outside New York City, and have been able to connect people in immigration detention to medical providers in Texas and California. Typically, we do not receive referrals for connection to a medical provider or any other assistance until the individual who is confined to immigration detention has met with an attorney or connected to a community-based organization.

10. Additionally, in February 2017 we published our findings in "Detained and Denied: Healthcare Access in Immigration Detention," based on our investigative work and research, including interviewing 47 people detained or recently detained at Hudson County Correctional Facility, Bergen County Jail, or Orange County Correctional Facility.[1] We recently completed a case file review of the nearly 100 individuals who contacted our network since this initial report and through the end of 2019. NYLPI will be publishing an updated version, "Still Detained and Denied," in Spring 2020.

11. In response to our 2017 report, New York Senator Kirsten Gillibrand, along with eleven other senators, wrote a letter to the Secretary of the Department of Homeland Security regarding access to healthcare in detention. Our work has been profiled in national journals, our team members have been interviewed and quoted in national media, and we have presented on our work and our medical-legal-community partnership to national legal audiences. Additionally, the New York City Mayor's Office of Immigrant Affairs has written in support of our project. Our staff members have testified before the U.S. Senate, the New York City Council and the New York State Assembly about the issues we have seen in our work, as detailed here.

12. The information referenced herein and that will be included in our updated report are based on interviews with people who are or have been detained, information NYLPI received in response to open records requests, and conversations with legal services providers, including the NYIFUP providers, community-based organizations, and

[1] Available at http://www.nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf.

families of people in immigration detention. Information included from other sources, such as reports issued by other advocacy organizations, is cited accordingly. This information was collected in the ordinary course of NYLPI's investigations and related work.

13. Although the information included herein is based on case file reviews of over 140 individual experiences, many of whom were connected with a medical provider to review their medical records or perform in-person consultations, we were unable to secure permission to include details of many people's experiences in this declaration because of fear of retaliation. Even individuals who have secured immigration relief, fear action by the current administration and have chosen to not speak publicly, even anonymously, about their experience. This apprehension is shared by many immigration attorneys on behalf of their clients.

Overview of Healthcare Provision at New York City-Area Detention Facilities:

14. Immigrants detained by ICE in detention facilities are said to be held primarily to ensure that they attend future administrative hearings concerning their right to remain in the United States. In the New York City area, immigrants with removal cases in the New York City immigration court are detained in jails including Hudson County Correctional Facility in Kearny, NJ; Bergen County Jail in Hackensack, NJ; Essex County Correctional Facility in Newark, NJ; and Orange County Correctional Facility in Goshen, NY. These facilities are local county jails with which ICE contracts to provide bed space. Collectively, I refer to these facilities throughout as "the NYC-area jails."

15. ICE has signed "Non-Dedicated Inter-Governmental Service Agreements" (IGSAs) with jails across the country to house people in civil immigration detention in the same fashion that the jails house the facility's criminal defendant population. ICE pays a daily per-bed fee to the county. These county facilities then often contract with for-profit companies to provide medical services.

16. ICE has issued standards that require providing adequate medical care to people in its custody. Upon intake in a detention facility, a person is supposed to receive a full medical screening no later than 12 hours after arrival at the facility and a comprehensive health assessment within 14 days of arrival to determine individual health care needs. Each person should receive a handbook, which explains the process for requesting medical assistance at the facility.[2]

[2] 2019 National Detention Standards Sections 6.1(I) (Handbook); 4.3(A)(1) and (D) (Screening); 4.3(E) (Health Assessment).

17. To receive medical assistance, a detained individual generally requests medical care from a kiosk in the living unit; the jails' medical unit should receive the request, and the medical staff is supposed to assess the request within 24 hours to determine priority for care. When specific treatment is needed, the facility's medical providers may submit requests to ICE for approval. When detained individuals need medical care that the facility is not equipped to provide, such as a surgery or a biopsy, they should be referred to hospitals outside of the correctional facility.[3] For example, Hudson County has formal agreements with local medical facilities for confined people to receive emergency room services. The standards also provide requirements for discharge planning and transfer of medical records.[4]

18. Since 2000, ICE has issued four sets of "Detention Standards" to address conditions of confinement for people held in detention facilities. These standards provide guidelines for hundreds of county jails and prisons throughout the United States. Each facility that holds people in ICE custody is evaluated by a designated set of standards.[5] The most robust standards were issued in 2011, referred to as the "2011 Performance Based National Detention Standards" (PBNDS), with a minimal update to non-relevant pieces in December 2016 -- yet ICE has always allowed many facilities to continue to follow the earlier and less robust iterations. In December 2019, the Trump administration issued adjustments to one of the earlier iterations, the 2000 National Detention Standards (NDS), which still applied to many facilities. The new 2019 NDS weakened many of already less robust provisions related to medical care, particularly related to oversight and accreditation.[6] The above requirements are included in all iterations.

Inadequacies in Medical Care in the NYC-Area Detention Facilities

19. People in immigration detention at the NYC-area jails are confined in jail-like conditions. In some circumstances, we have observed that the county facility provides services to the criminal defendant population that actually are not provided to people in immigration detention.

[3] 2019 National Detention Standards Sections 4.3(I) (Sick Call); 4.3(A) (specialist and outside care).
[4] 2019 National Detention Standards Section 4.3 (Q)(3)(b) and (Q)(4).
[5] For a list of ICE detention facilities and the standards by which they are evaluated, please see: https://www.ice.gov/doclib/facilityInspections/dedicatedNonDedicatedFacilityList.xlsx (last accessed Feb. 19, 2020).
[6] Hudson County follows the 2008 PBNDS, Essex County follows the 2011 PBNDS, and Bergen County and Orange County now follow the 2019 NDS.

20. Because of health disparities,[7] many immigrants suffer from chronic, serious health conditions and disabilities that require specialized care. People in immigration detention disproportionately suffer from serious health conditions, such as cancer, HIV, heart disease, hypertension, diabetes, and mental illnesses. People with serious illnesses are particularly vulnerable when they are confined to immigration detention facilities, because they require consistent and comprehensive care to manage their health. Many of these individuals have access to consistent healthcare in the community through Medicaid or private insurance, but detention breaks that connection, and their treatment is subsequently controlled by the immigration detention facility and ICE. Additionally, more people who have recently arrived after experiencing extreme trauma in nations in crisis are being detained, bringing new health concerns.

21. Once in detention, people face many barriers to quality healthcare, including lack of information on how to request medical assistance, institutional refusal of services, misdiagnosis, diagnosis of a less serious condition, lax oversight of their condition and/or treatment, failure to provide mental health discharge planning, and language access barriers. Confinement in immigration detention takes away a person's own ability to address their illness -- something many people we interviewed had been doing successfully for years before detention. Frequently, health problems occur and/or worsen shortly after a person is detained.

22. Additionally, many people in detention have other indicia of vulnerability, such as limited English proficiency, experiences of trauma, cognitive impairments, and/or limited education, which can create additional barriers to accessing what little care does exist in detention facilities.

23. NYLPI has documented significant and systemic problems regarding the conditions of confinement at the New York City-area facilities with respect to medical treatment and mental health care. The most serious issues include ICE and facility medical staff denying individuals vital medical treatment, such as dialysis and blood transfusions; subjecting sick people in need of surgery to unconscionable delays; altering established

[7] According to the United States Department of Health and Human Services, a health disparity is defined as, "a difference in health outcomes across subgroups of the population. Health disparities are often linked to social, economic, or environmental disadvantages." See United States Department of Health and Human Services, *HHS Action Plan to Reduce Race and Ethnic Health Disparities*, https://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf (last accessed Feb. 19, 2020). The American Medical Association refers to the findings of the Institute of Medicine, who state, among other things, that, "racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life." Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* Report and Recommendations on Health Disparities, 2003, *available a*t https://www.ama-assn.org/delivering-care/patient-support-advocacy/reducing-disparities-health-care (last accessed Feb. 19, 2020).

treatment regimens; failing to consistently provide needed mental health services and needlessly placing people with mental health problems (and others) in solitary confinement; and ignoring repeated complaints and requests for care from people with serious symptoms, including severe pain.

24. Throughout the course of our investigations, NYLPI documented recurrent deficiencies in care. In speaking with people detained or recently detained, we documented cases where deficiencies and the harms they cause happened in the early days of detention, which could not be remedied even by release.

25. Even short periods of detention – for example the period between arrest and bond hearing – can cause serious, lasting harm, including health harm not remedied by subsequent release. For example, people may experience heightened risk of infection from even short stays in detention. Treatment regimens are disrupted twice: once as the person detained struggles to secure care in detention, and a second time upon departing detention and confronting the need to reestablish treatment relationships or reintegrate into treatment systems and supports, inform medical professionals of what has transpired while in detention, regain entry into health-related programs, etc.

26. Repeated patterns NYLPI observes throughout the New York City-area jails include the following:

27. **Incomplete intake assessments:** In multiple instances, ICE and its contractors failed to act on information received during intake about a newly detained individual's medical history, including extreme delays in providing medication, with dangerous consequences to the patient's health.

28. **Denial of Continued Treatment Underway upon Admission:** Many individuals enter detention with medical issues, including medical problems exacerbated by health disparities, that require regular treatment. People report that medication they were taking, often for years or decades, is altered or entirely discontinued once they are detained. Even with clear directions on prescription medication and its importance, ICE and jails refuse to continue proven treatment, often harming health. For seriously ill people cut off from their continuing care in their communities by virtue of being detained, interrupted treatment can have severe consequences.

29. **Unprofessional and Inadequate Recording of Medical History and Care:** In or out of detention, an individual's medical records are a lifeline for medical providers to understand their needs. The records provide a critical basis for the ability to receive care. Clinical notes are essential for continuity of care. Medical professionals have an ethical

obligation to manage medical records appropriately. NYLPI and MPN volunteer physicians, who have reviewed tens of thousands of pages of medical records from New York City-area jails, report that the medical records regularly fail to meet professional standards. Without medical records up to standards, people recently detained risk losing time vital to recovery and sustaining their health.

30. **Language access barriers:** NYLPI's investigation found that ICE's failure to provide interpretation and translation services prevented many limited English proficient people from accessing medical care while confined in immigration detention. In one situation, NYLPI and our MPN volunteer spoke to an individual who was scheduled for surgery and had it performed - without being provided with an interpreter. These actions violate ICE's stated policies, as well as the American Medical Association's Code of Medical Ethics, implicating informed consent requirements when providing medical care.

31. **Delays in medical treatment:** One of the most pervasive problems people confined to immigration detention report is the ongoing struggle for timely responses to their requests for medical care. Even when a person is seen at intake or after a complaint, most often by a nurse and not a doctor, it can be weeks or months before pain or symptoms are addressed. Individuals may meet with nurses for months on end before they see a doctor who can formally diagnose symptoms and appropriately create a treatment plan. During this delay, pain and suffering worsen and medical consequences become more dire. Further, where evaluations are finally completed, there is additional delay in carrying out medical recommendations for surgery, specialist visits, and specific medication. Failures occur at many levels: sometimes internal county jail medical or non-medical personnel caused the delays; other times, ICE is the cause of delays through its failure to make timely determinations of whether to approve medical care.

32. **Denial of off-site care:** NYLPI has interviewed many people who required off-site and specialized medical care, which ICE either did not provide or provided only after extensive delay. When a detained individual needs inpatient or outpatient services, the facility medical provider refers the request to ICE Field Medical Coordinators. ICE Field Medical Coordinators approve or deny offsite services for ICE detainees. Many people have reported that ICE often denies these requests without providing any alternative care or reason for the denial. For example:

    - One man was experiencing rectal bleeding, which under the standard of care for a person of his age should quickly be seen by a gastroenterologist because of risks of colon cancer. This never happened.
    - An individual with a variety of heart conditions was denied requests for specialist visits and simply given aspirin.

- Another person had spinal surgery and was never taken for follow-up with the neurosurgeon specialist.

33. **Failure to manage chronic conditions:** Chronic illnesses, such as diabetes, cirrhosis, chronic heart and coronary diseases, hypertension, and depression and other mental health diagnoses require regular monitoring, evaluation, and treatment. The restrictive living conditions for people in immigration detention frequently exacerbate their health and well-being, particularly for people living with chronic illness. Deterioration can happen very quickly after being detained. NYLPI and our volunteers spoke to individuals in detention diagnosed with the above-referenced illnesses. In each circumstance, the person's medical records indicated failures to provide adequate medical care addressing these chronic conditions, all of which had been maintained and controlled prior to detention. People with entirely manageable chronic illnesses have faced life-threatening complications while in immigration detention, and many have died, including an individual whose family NYLPI represents, who died about two months after being detained.

34. **Ignoring acute pain:** NYLPI's investigation found that ICE and the New York City-area facilities routinely denied pain management treatment, leaving those with residual pain from prior injuries like car accidents or assaults to suffer excruciating pain. Interviewees reported pain so severe they were unable to carry out activities such as walking down the stairs or getting down from a bunk bed. One individual reported that his complaints were ignored until his pain was so extreme he had to be taken to the emergency room.

35. **Failure to identify and manage mental health problems:** Beyond the well-established negative psychological impact that confinement has upon people with mental illnesses,[8] NYLPI's investigation found that ICE and the New York City-area facilities routinely deny basic aspects of mental healthcare to people with mental illnesses. NYLPI's investigation found that for those who enter detention with a mental health diagnosis and daily medication needs, there is inconsistent continuation of vital regimens. People reported a range of experience. While some did receive daily medication and regular, although not necessarily substantive, psychiatric visits, others experienced complete denial of treatment plans that had allowed them to manage their illnesses for years prior to detention. For people without a diagnosis prior to detention or who demonstrate new symptoms while detained, the situation can be particularly dire. NYLPI and MPN physicians spoke to many people who demonstrated obvious symptoms of mental health problems, yet their needs and requests for care and evaluation were ignored.

[8] *See, e.g.*, M. von Werthern, K. Robjant, Z. Chui, R. Schon, L. Ottisova, C. Mason & C. Katona, "The impact of immigration detention on mental health: a systematic review" *BMC Psychiatry* volume 18, Article number: 382 (2018).

36. **Failure to provide basic accommodations to individuals with physical and mental health disabilities:** In our investigation we have seen disregard for the needs of people with disabilities. For example, one client was refused access to his wheelchair during an extended intake process, resulting in pain, anguish, and embarrassment. We have also spoken to people who were not provided aids for their visual or auditory disabilities, and our medical network volunteers have noted the ways in which detention and lack of care can cause individuals with mental health disabilities to decompensate, or that detention itself can cause mental health trauma to those without diagnoses.

37. **Deportation by detention:** NYLPI has also seen individuals in immigration detention accept deportation, giving up potential claims to stay in the United States, because of how much they are suffering in detention.

38. NYLPI is not the only organization to document widespread medical concerns at the New York City-area facilities.

39. In response to inadequate official inspections, Detention Watch Network (DWN) conducted an inspection in March 2016 of Hudson County Correctional Facility.[9] In "Hudson County Correctional Facility: Immigrant Detention Inspection Series," DWN interviews revealed "delays in medical care, inconsistencies with medical records and subsequent treatment, and inappropriate responses to health needs," such as being told by medical providers to "drink water for serious pain" or being given eyedrops for an ear infection. On May 10, 2016, Community Initiatives for Visiting Immigrants in Confinement (CIVIC)[10] filed a complaint against DHS, ICE, and Hudson County officials on behalf of 61 men and women detained by ICE at Hudson County Correctional Facility alleging substandard medical care.[11] In February 2018, Human Rights First released a similar report highlighting deplorable access to physical and mental healthcare for the people detained at Hudson County Correctional Facility.[12] In June 2018, Human Rights Watch released a report focused on the numerous deaths in immigration

[9] Detention Watch Network, *Hudson County Correctional Facility: Immigrant Detention Inspection Series* (2016), *available at* https://www.detentionwatchnetwork.org/sites/default/files/Hudson%20Inspection_DWN_2016.pdf (last accessed Feb. 19, 2020).
[10] Since filing this complaint, CIVIC has changed its name to Freedom for Immigrants.
[11] The complaint is available at https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/5a9db03153450a5c990951d3/1520283698321/New_Jersey_Medical_Complaint_Final.pdf (last accessed Feb. 19, 2020).
[12] Human Rights First, *Ailing Justice—New Jersey: Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention* (2018), *available at* https://www.humanrightsfirst.org/press-release/new-report-documents-physical-mental-health-care-deficiencies-new-jersey-detention (last accessed Feb. 19, 2020).

detention.[13] In October 2019, the Center for American Progress published a report about failures and dangers related to women's health access in immigration detention.[14]

40. The United States government itself has also concluded medical care appeared delayed and was not properly documented in NYC-area facilities, particularly Hudson County Detention Center, in a December 2017 Department of Homeland Security Office of Inspector General report.[15] Additionally, in March 2019 the U.S. Department of Homeland Security received complaints about failure to provide adequate medical and mental health care and oversight at ICE-run detention facilities, including Elizabeth Contract Detention Center in New Jersey. That investigation is ongoing.[16]

41. The deep deficiencies in medical care provided to immigrants confined in detention can have serious and even life-threatening results very quickly after detention, as illustrated tragically by the case of Carlos Bonilla.[17] As reported by Human Rights Watch in "Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention" and set forth in NYLPI's pending lawsuit,[18] Mr. Bonilla, a father of four, fatally hemorrhaged after approximately two months after being taken into civil immigration detention. He had cirrhosis, a chronic liver disease that, if left untreated, can cause deadly complications. Prior to ICE's arresting him, Mr. Bonilla had been receiving medical treatment for years, including prescriptions for medications necessary to prevent and manage complications of cirrhosis. Mr. Bonilla reported his history of cirrhosis when he arrived at immigration detention, but the facility and medical providers did not evaluate the progression of Mr. Bonilla's illness and provide treatment for cirrhosis and cirrhosis complications. Mr. Bonilla bled for at least three days before he -- tragically and preventably -- hemorrhaged to death. He was transported by ambulance to the hospital on the very date that he was scheduled to appear before an immigration judge to determine whether he would be released on bond to his family and community.

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[13] Human Rights Watch, *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention,* June 20, 2018, *available at* https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration (last accessed Feb. 19, 2020).
[14] Center for American Progress, *Immigration Detention Is Dangerous for Women's Health and Rights*, October 21, 2019, *available at* https://www.americanprogress.org/issues/women/reports/2019/10/21/475997/immigration-detention-dangerous-womens-health-rights/ (last accessed Feb. 19, 2020).
[15] United States Department of Homeland Security, Office Inspector General, *Concerns about ICE Detainee Treatment and Care at Detention Facilities* (2017), *available at* https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf (last accessed Feb. 19, 2020).
[16] United States Department of Homeland Security, Office of Civil Rights and Civil Liberties, March 20, 2019, *available at* https://www.documentcloud.org/documents/6575024-ICE-Whistleblower-Report.html (last accessed Feb. 19, 2020).
[17] NYLPI represents Mr. Bonilla's family in federal litigation, *Bonilla v. Hudson County*, United States District Court for the District of New Jersey, Case No 19:13137 (2019).
[18] *Id.; supra* note 8.

42. Mr. Bonilla's death is one of at least 17 reported at Hudson County Correctional Facility since 2013.[19] The deaths prompted the Hudson County Freeholder Board to approve a resolution for a medical review board to analyze the deaths[20] and to terminate its contract with health provider CFG Health Systems, LLC. Nonetheless, Essex County Correctional Facility continues to contract with CFG for healthcare services.[21] In response to public outcry, including expressions of outrage after the death of Carlos Bonilla, in December 2018 Hudson County officials proposed to end their contract with ICE, although they included an option to renew.[22] No other New York City-area detention jails have taken similar action.

43. NYLPI's client Geurys Sosa also received egregiously inadequate medical care while confined by ICE to civil immigration detention for seventeen months at Hudson County Correctional Center.[23] Prior to being detained, Mr. Sosa was receiving appropriate and uninterrupted treatment for two serious autoimmune diseases. Despite the medical staff knowing of Mr. Sosa's diagnoses, he was wrongly denied essential medical treatment, including specialty care and medications he desperately required. As a result, Mr. Sosa's health rapidly deteriorated, resulting in needless pain and suffering and contributing to permanent injury.

44. There are numerous other examples of how people with serious medical conditions are often unable to get appropriate—and sometimes life-saving—medical care until after they are released from detention:

    a. For Mr. Gomez, Mr. Golden, and Mr. Xe, all detained at Hudson County Detention Facility, a consulting board-certified endocrinologist evaluated their medical records and found that, under the current regime overseen by ICE, all three people were at risk of infections and diabetic complications such as retinopathy, renal failure, heart attack or strokes—even while on their insulin

[19] *Id.* at Dkt No. 1 (Complaint) para 8.
[20] Terrence T. McDonald, The Jersey Journal, *Hudson County to pay $70k to probe deaths of jail inmates* (Aug. 11, 2017), *available at* https://www.nj.com/hudson/index.ssf/2017/08/hudson_county_to_pay_70k_to_probe_deaths_of_jail_i.html (last accessed Feb. 19, 2020).
[21] CFG Health Systems, LLC, *Client Locations*, available at https://cfghealthsystems.com/client-locations/ (last accessed Feb. 19, 2020).
[22] Alfaro, Maria, *Democrats Battle Over a New Jersey Jail's Contract With ICE*, New York Times, August 31, 2018, *available at* https://www.nytimes.com/2018/08/31/nyregion/new-jersey-jails-ice.html (last accessed Feb. 19, 2020); *see also* Alvarado, Monsey, *Hudson County is looking for other revenue so it can end contract to house ICE detainees*, December 27, 2019, *available at* https://eu.northjersey.com/story/news/new-jersey/2019/12/27/hudson-nj-seeking-other-revenue-so-can-end-contract-house-ice-detainees/2749774001/ (last accessed Feb. 19, 2020).
[23] NYLPI represents Mr. Sosa in federal litigation, *Sosa v. Hudson County*, United States District Court for the District of New Jersey, Case No 2:20-cv-00777 (2020). The case is co-counseled with Quinn Emanuel Urquhart & Sullivan LLP and Neighborhood Defender Service of Harlem.

regimen. Hudson County only provided the detainees with a diet full of excessive complex carbohydrates including pasta, white bread, white rice, potatoes and cookies, all foods extremely detrimental to their health. Further, ICE refused to provide dentures to two people who, because of their diabetes, were suffering from gum disease and losing their teeth. ICE also refused to provide them with glasses despite their deteriorating vision, another type of diabetic complication. One individual reported rashes all over his body and pain in his leg and foot region that if left untreated could have led to amputation. All three individuals were eventually released on bond by an Immigration Judge based partly upon evidence of inadequate healthcare.

b. Mr. Ahmed suffers from second-degree heart atrioventricular block, a condition in which the normal electrical conduction in the heart that allows for a regular heart rate and rhythm is disrupted. He uses a pacemaker to treat his condition. Pacemakers need regular monitoring and maintenance to detect malfunctioning, preserve normal cardiac function, and prevent potentially life-threatening arrhythmias. Beginning in 2015, Hudson County Correctional Facility failed to monitor his pacemaker and put his life in jeopardy. Several times while feeling chronic symptoms of distress, Mr. Ahmed requested to see a specialist. ICE and Hudson County Correctional Facility repeatedly refused these requests. During an immigration hearing, Mr. Ahmed was so obviously in bad health, weak, and short of breath that the presiding judge called paramedics to take him to a hospital. At the hospital, doctors performed emergency surgery to replace his pacemaker battery. When he returned to detention, Mr. Ahmed experienced symptoms suggesting that his pacemaker was malfunctioning, including fatigue, shoulder pain and swelling, cramps in his foot, heart palpitations at night, difficulty breathing, dizziness, and inability to swallow. ICE and Hudson County Correctional Facility again refused to permit him to see a specialist who would have the technology needed to test whether the pacemaker was working properly.

c. Mr. Lugo was detained at Hudson County Correctional Facility and is the primary caregiver for his elderly partner who suffers from several chronic conditions. At the time of his detention, Mr. Lugo was diagnosed with Stage III Chronic Kidney Disease, a serious medical condition which requires close monitoring by a nephrologist (a doctor who specializes in diseases of the kidneys) because it can progress to kidney failure; which is life-threatening. Mr. Lugo was also diagnosed with diabetes and other collateral ailments such as cataracts disease, which poses a risk of blindness. Prior to his detention, Mr. Lugo regularly met with a nephrologist who closely monitored his disease. However, in the first five months of Mr. Lugo's detention, he had bloodwork performed only once, and

there was no indication that a nephrologist reviewed the results. In the same period, Mr. Lugo was not provided necessary medication or seen by an ophthalmologist to treat and monitor his eye disease. Further, while detained, the jail did not provide Mr. Lugo with meals that accommodated his diabetes or kidney disease; as a result, he was unable to eat and lost 18 pounds in the course of one week.

Impact of ICE's Refusal to Release on the Health of Detained Individuals

45. ICE has the authority to release an individual on recognizance, on administrative bond, or on "humanitarian parole" for health-related reasons. But despite zealous advocacy by legal advocates, it is extremely difficult to secure the release of sick individuals from detention. In fact, NYLPI has found that virtually no one is released by ICE, even when ICE is clearly failing to meet medical needs. ICE frequently does not even respond to advocates' requests for better care for clients.

46. NYLPI's experience and our collaborations with legal service providers demonstrate that individuals in immigration detention risk severe damage to their health if they are not released back into their communities. NYLPI frequently connects individuals to medical providers to provide supporting letters to Immigration Judges outlining the lack of medical care at the detention facilities, which have helped people confined to immigration detention receive a reasonable bond and release. In recent years, NYLPI has coordinated numerous in-person consultations between volunteer medical providers and people in detention. Through these visits providers are able to gain greater insight into the client's health conditions, and also observe general impressions, such as how detention itself harms mental health.

47. We have found that, even where an advocate has succeeded in securing the release of an individual with unmet medical needs, serious and possibly irreversible damage to the person's health often has already occurred. As seen through the above examples, delay in care, improper care, and denial of care can result in needing emergency services, extensive hospitalizations, intensive care upon an individual's release back into the community and permanent health damage – all for health issues that, if treated appropriately, could have reduced or averted injury, pain, and even death.

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

Executed March 10, 2020

Marinda van Dalen