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IN THE UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. ARMANDO ACOSTA TORO, Defendant.	Case No.: 1:19 CR 256 NONE/SKO **MOTION TO REVOKE PRETRIAL DETENTION ORDER DUE TO DANGER STEMMING FROM COVID-19 COMPLICATIONS; ATTACHMENTS IN SUPPORT THEREOF; DECLARATION OF KEVIN P. ROONEY IN SUPPORT THEREOF** Date: March 27, 2020 Time: 8:30 a.m. Location: Hon. Dale A. Drozd

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Summary of Argument[1]

This motion to revoke the detention order is brought to protect the health and safety of defendant Toro and the health and safety of the entire community. The United States is in the early stages of a pandemic. An extraordinarily contagious disease, and the equally extraordinary and crucial efforts to contain it, are impacting the lives of every person in the United States. On

Mr. Toro is a 62 year-old man who suffers from diabetes along with high blood pressure and high cholesterol. Mr. Toro's age and medical conditions put him at an extremely high risk of serious complications and death if he is infected with COVID-19.

[1] There are numerous previous filings stemming from earlier motions contesting Mr. Toro's detention. Defense counsel will present all necessary facts and argument in this 'stand-alone' brief.

If Mr. Toro remains detained, he is extremely likely to become infected with COVID-19. Once infected, there is a one in ten chance he will die.

Contrary to the government's previous arguments, there is no doubt Mr. Toro's risk of infection will be dramatically reduced if he is released from custody. Social isolation is the primary and most effective means to avoid infection. At the Fresno County Jail, Mr. Toro shares sleeping quarters with 8 or 9 other inmates and a 'day-room' with approximately 65-75 inmates. Those crowded conditions, along with other unavoidable aspects of custodial facilities, render inmates very susceptible to contagious illnesses. If released, Mr. Toro will share a four-bedroom, single-family home with his daughter, her spouse, and two teenagers. Mr. Toro would have his own bedroom in that home – a striking contrast to the conditions at the Fresno County Jail.

Moreover, leaving Mr. Toro in custody to become infected with COVID-19 endangers the entire community, not just Mr. Toro. Whether or not Mr. Toro eventually succumbs to COVID-19, his medical care will drain urgently needed resources from the community. The emerging consensus among public health experts is that it is absolutely critical to reduce the number of people incarcerated in order to both contain the spread of COVID-19 and to reduce the impact on medical resources. Given these facts, Mr. Toro's continued detention cannot be justified.

This Court has the statutory authority, as well as the inherent judicial power, to revoke the PreTrial Detention order and release Mr. Toro.

Finally, in the prosaic terms of pre-COVID-19 analysis, Mr. Toro does not pose an unreasonable risk of danger to the community or flight. PreTrial Services indicated that conditions could be fashioned to appropriately address potential danger to the community.

Mr. Toro is not a flight risk. He is a lawful permanent resident of the United States. He has lived in the Fresno area since 1976 and his ties to Fresno include four adult children,

ten grandchildren, and a sister. He worked steadily in the Fresno restaurant industry for over forty years. Mr. Toro's daughter, Monica Acosta, is willing to serve as third-party custodian and his daughters will pledge their vehicles as security despite their limited financial resources.

Background[2]

A. COVID-19 surfaces in China & spreads worldwide

COVID-19 is a viral respiratory illness caused by a novel coronavirus first identified, in Hubei Province, China, in December 2019. *See* CDC, *What you need to know about coronavirus disease 2019 (COVID-19)*, available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf; *see also* New Scientist, *Covid-19*, available at https://www.newscientist.com/term/covid-19/. Since its discovery in Wuhan, cases of COVID-19 have spread to over 114 countries. *See* UN News, *Coronavirus: Pandemic alert should be trigger for countries to do more against COVID-19* (Mar. 11, 2020), available at https://news.un.org/en/story/2020/03/1059231. The World Health Organization's most recent Situation Report on COVID-19 identifies 125,048 confirmed global cases of COVID-19, and 4,613 deaths. *See* World Health Organization, *Coronavirus disease 2019 (COVID-19): Situation Report—52* (Mar. 12, 2020), available at https://www.who.int/docs/default-source/coronaviruse/20200312-sitrep-52-covid-19.pdf?sfvrsn=e2bfc9c0_2.

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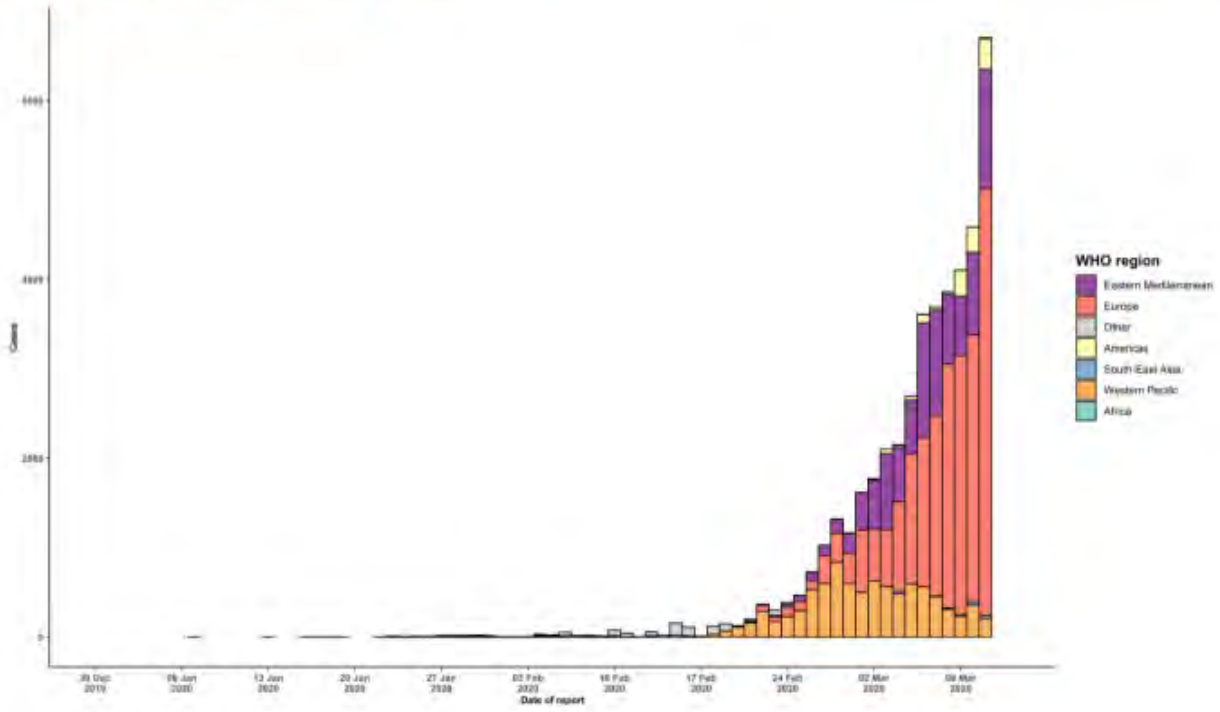
[2] As the Court knows, this situation is extremely fast moving. This briefing is based on the best science available as of March 16 and 17, 2020. By the time this motion is heard, the situation is likely to be more severe. Undersigned Counsel has adopted the vast bulk of the scientific facts presented in this motion from exhaustive work done by the Federal Defender's Office in the Western District of Washington.

B. COVID-19 is continuing to spread exponentially

The virus is spreading exponentially. Overall, COVID-19's basic reproduction number is somewhere between 2.4 and 3.8, which means that "each newly infected person is estimated to infect on average 3 additional persons." Beyrer Dec. ¶ 10. Because of this, the virus is spreading at a rapidly accelerating rate. The WHO's epidemic curve from March 12, 2020 confirms this alarming acceleration:

Figure 2. Epidemic curve of confirmed COVID-19 cases reported outside of China (*n*= 44 067), by date of report and WHO region through 12 March 2020



And here is data since this date in tabular form:

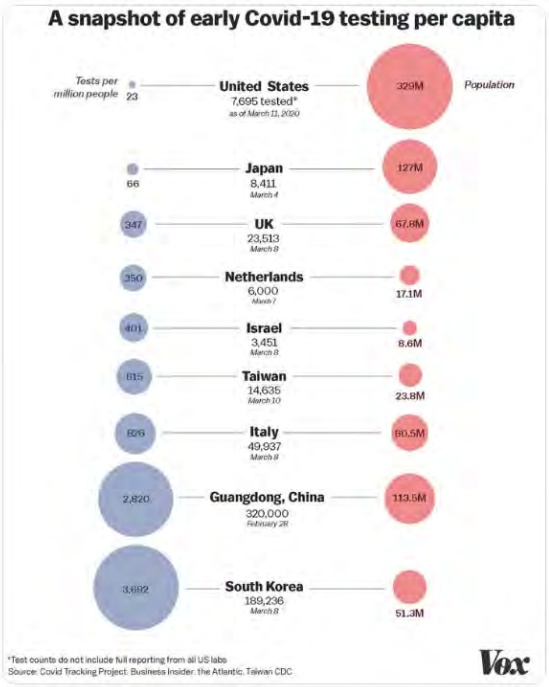
Date	Total Cases	Cases Since Yesterday
03.16.2020	167,511	13,903
03.15.2020	153,517	10,982
03.14.2020	142,534	9,764
03.13.020	132,758	7,499
03.12.2020	125,048	6,729

COVID-19 is spreading exponentially.

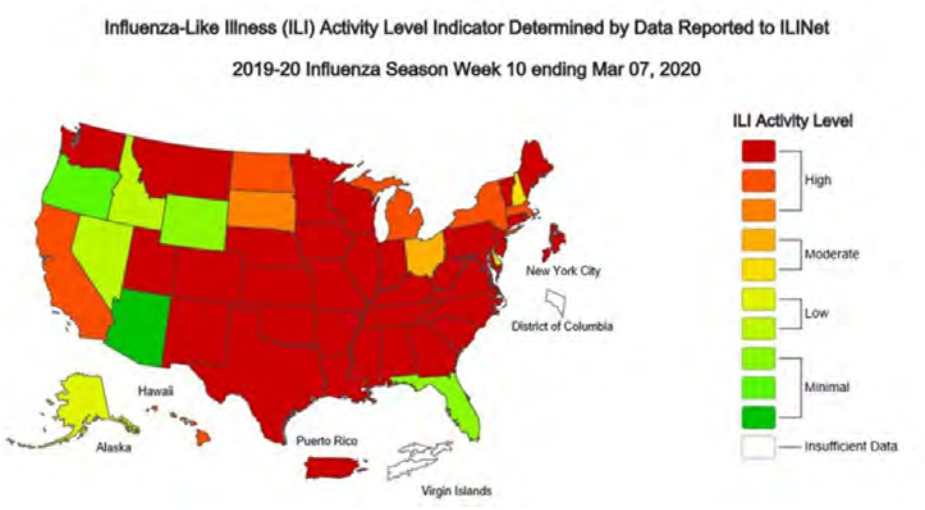
C. COVID-19 is an uncontained pandemic in the United States

On March 18, California Governor Newsom wrote to President Trump and requested that a hospital ship be sent to serve the Los Angeles area. Newsom stated that "We project that roughly 56 percent of our population – 25.5 million people – will be infected with the virus over an eight week period." Since January 2020, COVID-19 has spread widely in the United States. It has now been detected in 49 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. *See* CDC, *COVID-19 Cases in the US*, available at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. On Monday morning, March 23, 2020, as undersigned counsel was finalizing this brief, there were 33,018 discovered COVID-19 cases in the United States and 1,849 cases in California with 33 deaths. *See* Mitch Smith, et al., *Tracking Every Coronavirus Case in the U.S.: Full Map*, NYTimes (updated March 22, 2020), *available at* https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html. Washington State has 1, 844 reported COVID-19 cases with 98 deaths. Washington state's mortality rate is 5.3% as opposed to California's 1.7%. There are two likely explanations for the different mortality rates between the states. First, the COVID-19 pandemic got started earlier in Washington than California, allowing more time for the disease and its complications to kill people. Secondly, as widely reported, Washington State had significant outbreaks in nursing homes and nursing homes have vulnerable residents.

The reported number of COVID-19 cases and associated deaths almost certainly understates the problem, as community spread has been ongoing starting in Washington State in January 2020, and the United States is vastly behind where it needs to be in testing for this virus:



While the United States has not yet performed enough tests to accurately capture the true scope of this disease within its borders, the overall trend in the United States indicates continued exponential growth in cases of COVID-19. Consider, for example, that even though we are at the tail end of flu season, reports of flu-like symptoms nationwide are unusually high:



This virus has been spreading exponentially.

D. COVID-19 is far deadlier than the flu

COVID-19 is an extremely dangerous disease. The best estimate for its overall fatality rate—i.e., its fatality rate among all demographics—is 0.3-3.5%, "which is 5-35 times the fatality associated with influenza infection." Beyrer Dec. ¶ 5; *see also* Nick Wilson et al., *Case-Fatality Risk Estimates for COVID-19 Calculated by Using a Lag Time for Fatality*, 26(6) EID Journal (prepublication June 2020), *available at* https://wwwnc.cdc.gov/eid/article/26/6/20-0320_article. Fatality rates vary wildly, however, depending on both environmental and demographic risk factors.

E. COVID-19 places certain population groups at greater risk

COVID-19 causes some population groups to die at far greater rates than others. A person's likelihood of dying from this disease varies dramatically depending on two key factors: 1) their demographic profile and 2) the environment where they live.

1. COVID-19 kills the sick and elderly

COVID-19's death rate goes up 1) the older you are and 2) the sicker you are. The death rate increases *dramatically* with age. The best current evidence is that people aged 10-39 years are stand a roughly 0.2% chance to die from COVID-19 (still a mortality rate double the influenza mortality rate). Then the death rate starts going up:

Age	**Case Fatality Rate**
40-49 years old	0.4%
50-59 years old	1.3%
60-69 years old	3.6%
70-79 years old	8%

80+ years old	14.8%[3]

COVID-19 also kills the sick. *See* Beyrer Dec. ¶ 6. COVID-19's comorbidity death rate is frightening. Across all age groups, COVID-19 kills:

Condition	**Case Fatality Rate**
Cardiovascular disease	13.2%
Diabetes	9.2%
Hypertension	8.4%
Chronic respiratory disease	8%
Cancer	7.6%[4]

In Wuhan, of the hospitalized population who ended up dying from COVID-19, 48% of them had hypertension, 31% had diabetes, and 24% had coronary heart disease. *See* Fei Zhou et al., *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*, Lancet (Mar. 11, 2020), *available at* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[3] This information derived from analysis of deaths in Hubei Province, China.

[4] *See* World Health Organization, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* at 12 (Feb. 28, 2020), *available at* https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf; *see also* Wei-jie Guan et al., *Comorbidity and its impact on 1,590 patients with COVID-19 in China: A Nationwide Analysis*, medRxiv at 5 (Feb. 27, 2020), https://www.medrxiv.org/content/10.1101/2020.02.25.20027664v1.full.pdf (finding that even after adjusting for age and smoking status, patients with COVID-19 and comorbidities of chronic obstructive pulmonary disease, diabetes, hypertension, and malignancy were 1.79 times more likely to be admitted to an ICU, require invasive ventilation, or die, and the number for two comorbidities was 2.59).

For these reasons, the best epidemiological advice to deal with this national health emergency is that "[o]lder inmates and those with chronic conditions predisposing to severe COVID-19 disease . . . should be considered for release." Beyrer Dec. ¶ 18.

2. COVID-19 poses acute risks to inmates and correctional staff.

A. General Considerations

Incarceration poses a ***grave public health threat*** during this crisis. "COVID-19 poses a serious risk to inmates and workers in detention facilities." Beyrer Dec. ¶ 11. It is well-known in the epidemiological community that such facilities are "associated with high transmission probabilities for infectious diseases." Beyrer Dec. ¶ 11; *see also* Joseph A. Bick (2007). Infection Control in Jails and Prisons. *Clinical Infectious Diseases* 45(8):1047-1055, *at* https://doi.org/10.1086/521910; Laura M. Maruschak et al. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. NCJ 248491. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, *at* https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf. Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases. *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) *at* https://bit.ly/2TNcNZY.

When outbreaks occur in custodial facilities, those illnesses lead directly to increased spread beyond those institutions. *See* Beyrer Dec. ¶ 12. "It is therefore an ***urgent priority*** in this time of national public health emergency to reduce the number of persons in detention as quickly as possible." Beyrer Dec. ¶ 17 (emphasis added).

COVID-19 is coming to the Fresno County Jail. It's not a question of if, but when. COVID-19 has already appeared in multiple prisons in China. *See* Beyrer Dec. ¶ 15. Precautionary measures may be helpful in delaying the onset of COVID-19 in the jail but the admission of new arrestees, staff contacts, transportation to court and other venues, combined

with the extraordinarily infectious nature of this disease, makes it inevitable that COVID-19 will infect many Fresno County Jail inmates.

When COVID-19 arrives in Fresno County Jail, as it will soon, the ramifications for both the incarcerated population and correctional staff will be dire. "Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities." Beyrer Dec. ¶ 13. Social distancing and decontaminating surfaces is "virtually impossible." *Id.* Furthermore, "[t]he high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure." *Id.*

It is inherently difficult to manage infectious diseases in a custodial facility, *see id.*, and the fact that the government insists on business as usual is highly troubling. By contrast, on March 20th , California Supreme Court Chief Justice Cantil-Sakuye issued the following guidance to California Courts:

> -Lower bail amounts significantly for the duration of the coronavirus emergency, including lowering the bail amount to $0 for many lower level offenses.
>
> -Consider a defendant's existing health conditions, and conditions existing at the anticipated place of confinement, in setting conditions of custody for adult or juvenile defendants.

At this moment in our national history there can be no doubt: "[r]eleasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole." Beyrer Dec. ¶ 19.

B. The Fresno County Jail Had A Mumps Outbreak Earlier This Year

Not surprisingly, the Fresno County Jail has experienced previous outbreaks of infectious disease. In January and February this year, there was a mumps outbreak *See,* Press release from the Fresno County Sherriff's Office dated January 30, 2020; Fresno County Superior Court's 2nd order regarding quarantined inmates; ABC 30.com report March 11, 2020 report "Quarantine shrinks". Notably, the Fresno County Assistant Public Health Director told the media that conditions in the Fresno County Jail required more precautions against contagion than required in non-custodial settings. Defending the inmate quarantine's duration, the Assistant Public Health Director said, "CDC [Center For Disease Control] recommendations don't necessarily apply in places like jails where people live in very close proximity to each other." Those comments support the defense contention in this case that continued detention renders Mr. Toro extremely vulnerable to COVID-19 and complications.

The Fresno County Jail reported twelve cases of mumps in the recent outbreak. Mumps are much less contagious than COVID-19. Many people have immunity to mumps, either from prior exposure or vaccination. No one, not a single person, is immune from COVID-19.

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3. COVID-19 poses an extreme risk to Mr. Toro

Mr. Toro is particularly at- risk from COVID-19. He is 62 years-old, and suffers from diabetes, high blood pressure, and high cholesterol. If infected, Mr. Toro's age alone makes him 18x more likely than a younger person (age 10-39) to die; the mortality rate increases from .02% to 3.6%.[5] Mr. Toro's health conditions are even more impactful – diabetes yields a 9.2% mortality rate (460x the younger person's mortality rate) and hypertension yields an 8.4% mortality rate (420x the younger person's mortality rate). The mortality rate from the combination of these conditions – advanced age, diabetes, and hypertension – is not available to counsel but the combination is certainly not favorable.

ARGUMENT

A. Statutory Bases For PreTrial Release Due To Vulnerability To COVID-19

The Bail Reform Act, 18 U.S.C. §3142(g)(3)(A), specifically includes an accused's health as a factor to be considered in assessing reasonable conditions of release. Moreover, detention or conditions of release cannot be excessive in relation to the permissible purposes of assuring a defendant's appearance and/or protecting the community. *Bell v. Wolfish*, 441 U.S. 520, 538 (1979); *United States v. Rueb*, 612 F.Supp.2d 1068, 1072 (D. Neb. 2009). The COVID-19 outbreak, and Mr. Toro's vulnerability to complications from what appears to be a nearly inevitable infection if he remains in custody, has radically altered the circumstances which this court must consider in deciding whether to detain or release Mr. Toro. Continued pretrial detention seriously endangers his health and therefore is excessive. Continued detention also endangers the community.

The Bail Reform Act and longstanding precedents support Mr. Toro's release due to the COVID-19 pandemic. Any doubts about the propriety of release should be resolved in favor of

[5] The analysis of Mr. Toro's increased risk is based on the tables presented earlier as well as the attachments to this motion.

the defendant. *United States v. Townsend*, 879 F.2d 989, 994 (9th Cir. 1990). Statutorily, PreTrial detention is permissible only if the Court finds that no condition of release, or combination of conditions, would reasonably assure the defendant's appearance and the safety of the community. 18 USC §3142(e)(1). Given the constitutional requirements of the presumption of innocence and due process, neither pretrial detention nor conditions of pretrial release can be punitive in nature. *United States v. Salerno*, 481 U.S. 739, 750-52 (1987); Bell *v. Wolfish*, 441 U.S. at 538.

The parties agree that the Bail Reform Act permits the reopening of a detention hearing for 'changed circumstances' – new information with a material bearing on detention issues. 18 U.S.C. §3142(f). The Act also specifically authorizes the court to permit the temporary release of a person previously ordered detained, to the custody of an appropriate person, to the extent the court determines such a release to be necessary for a compelling reason. 18 U.S.C. §3142(i)(4). Mr. Toro's susceptibility to COVID-19 complications is a compelling reason and his daughter Monica is an appropriate third-party custodian.

B. The Government Previously Mischaracterized Mr. Toro's Contentions and The Applicable Law

The government has previously argued that:

> The COVID-19 outbreak is not "material" to the issue of detention, however, because no section of the Bail Reform Act authorizes the district courts to make public health decisions on behalf of Federal detainees. Clearly, the Bail Reform Act asks courts to weigh as a detention factor the Defendant's "physical and mental condition". (statutory citation omitted) But nothing in the Act supports the Defendant's argument that during the time of a public emergency, the Bail Reform Act shall be effectively suspended, to the extent that a Defendant believes he is safer in the care of a family member than in the care of the United States Marshals Service. Further the United States believes that (1) the Fresno County Jail has screening procedures for COVID-19, and (2) there have been zero reported cases of COVID-19 at the Fresno County Jail. He simply cannot argue with any

> evidentiary support that he would be safer on release than he would be in custody. That fact is unknown, and potentially unknowable at this time. (Document 142, p. 4)

The government's arguments mischaracterized Mr. Toro's contentions and misconstrued the law. Mr. Toro has presented scientific evidence, not his subjective beliefs, to establish the danger he, and the community, face from his continued detention[6]. That scientific evidence establishes that Mr. Toro, and the community, will be far safer if he is released from custody. The government's refusal to acknowledge scientific facts is troubling.

Secondly, the government wrongly contends that this Court is without power to intercede when a public health crisis causes detention to imperil both a defendant's and the community's health. The government recognized that Bail Reform Act expressly permits bail determinations to be reconsidered due to changed circumstances and attempted to circumvent that statute. The government conceded that the COVID-19 pandemic is "new information" but claimed the pandemic does not have a "material bearing" on the issue of detention "because no section of the Bail Reform Act authorizes the district courts to make public health decisions on behalf of Federal detainees". Document 142, p. 3-4. That argument fails on numerous grounds.

Before the COVID-19 pandemic, Mr. Toro's PreTrial detention curtailed his liberty. Now, PreTrial detention endangers his life and the lives of others. That new consideration – literally the possibility of life or death - is material. Using the statutory terms, 'reasonably assuring Mr. Toro's appearance' is materially impacted by the changed circumstance that continued detention endangers his life. *See*, 18 U.S.C. §3142(f)(2)(B). 'Reasonably assuring the safety of the community' is materially impacted by changed circumstances such that continued detention endangers, instead of protects, the community.

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[6] Mr. Toro's original filing contained information from the CDC and media reporting. Counsel subsequently provided the Magistrate Judge and government counsel additional media reports and NDCA Magistrate Judge Couzen's Standing Order regarding reopening bail matters due to the "Coronavirus pandemic".

The government argued that the pandemic does not have a "material bearing" on the issue of detention "because no section of the Bail Reform Act authorizes the district courts to make public health decisions on behalf of Federal detainees. The Act sets out the Court's authority to reopen a detention hearing in general terms; it does not specify what events and circumstances could be material to considerations of reasonable conditions of release. *See,* 18 U.S.C. §3142(f)(2)(B). The statute does not list the qualifying material events and circumstances for reopening because that materiality determination was (wisely) left to the discretion of the Court. There are innumerable events and circumstances that could be material and it would be impossible to anticipate and list them all. The "absence" of a statutory provision directly addressing the court's authority to revisit a detention order because continued detention during an ongoing pandemic endangers both the defendant and the community, does not limit this Court's authority. In addition, this Court has inherent judicial authority to revisit its decisions when the underlying assumptions or circumstances have changed – for example when PreTrial detention changes from a curtailment of liberty to a significant threat to the health and safety of the detained and the community.

The government also misconstrued Mr. Toro's alternative contention that release is appropriate because the Bail Reform Act specifically authorizes the court to permit the temporary release of a person previously ordered detained, to the custody of an appropriate person, to the extent the court determines such a release to be necessary for a compelling reason. 18 U.S.C. §3142(i)(4). The government argued, "The United States cannot locate any authority, nor does the Defendant cite to any, that a **person's personal belief about his/her personal and medical safety** in a time of a public health emergency constitutes a compelling reason [under the Bail Reform Act." Document 142, p. 5, emphasis added. Mr. Toro has never relied on his personal beliefs; scientific evidence establishes that continued custody endangers both Mr. Toro and the community.

C. Mr. Toro's continued detention cannot be justified

The courts have long recognized their responsibility to keep a defendant alive, no matter the charge. "We do not punish those who have not been proven guilty. When we do punish, we do not act cruelly. Continued incarceration of this terminally ill defendant threatens both of these fundamental characteristics of our democracy." *United States v. Scarpa*, 815 F.Supp.88 (E.D.N.Y. 1993) (pretrial defendant with AIDS facing murder charges released on bail because of the "unacceptably high risk of infection and death on a daily basis inside the MCC.)

Mr. Toro is subject to a tremendous health risk if he remains detained. He is a 62 year-old man with diabetes, high blood pressure, and high cholesterol. People with diabetes have a 9.2% mortality rate from COVID-19. Hypertension has an 8.4% mortality rate from COVID-19. Mr. Toro's age alone would make him about 18x more likely to die from COVID-19 than someone in their thirties even without his compromised health. "[V]ulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised . . . living in an institutional setting . . . are at grave risk of severe illness and death from COVID-19." Golob Dec. ¶ 14. Any argument by the government that Mr. Toro is equally safe whether detained or released is contrary to all scientific evidence. The unavoidable truth is that Mr. Toro's continued detention has a significant chance of killing him.

D. Mr. Toro's continued detention poses a grave risk to the community.

Mr. Toro's continued detention also poses a grave risk to the community. The more people remain detained in detention facilities, the greater the likelihood of an unchecked outbreak of COVID-19 within our detention facilities and jails. *See* Beyrer Dec. ¶ 11. Such an outbreak will impact inmates, correctional officers, and the communities of which those inmates and officers are a part. When Mr. Toro contracts COVID-19 in the Fresno County Jail, he will very likely escalate to critical condition, consuming limited medical resources needed to treat others. He will also serve as one more vector for COVID-19's spread. Consequently, Mr. Toro's continued detention endangers the entire community.

It is unusual for detention to endanger a community rather than protect it. Public health demands this 'paradigm shift'; Mr. Toro's release to protect the community. At this time, incarceration poses a grave public threat, such that we must accept some risk from pretrial release to protect our communities from the dangers posed by an outbreak in the inmate population followed by community spread and overwhelmed medical resources. The epidemiological community speaks with one voice on this point:

- Dr. Beyrer from Johns Hopkins University: "Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole." Beyrer Dec. ¶ 19.
- Dr. Greifinger: "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. In my opinion, the public health recommendation is to release high-risk people from detention[.]" Greifinger Dec. ¶ 13.
- Dr. Stern: "As a correctional public health expert, I recommend the release of eligible individuals from detention, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19." Stern Dec. ¶ 11.
- Dr. Meyer, an Assistant Professor of Medicine at Yale School of Medicine: "Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large." Meyer Dec. ¶ 37.

Releasing Mr. Toro will protect, not endanger, the community.

D. Considerations Regarding Flight And Danger Favor Release

The government and defense counsel agree that the Court must consider Mr. Toro's risk of flight or danger when considering this motion for release. When making that determination, the ongoing pandemic will be a significant part of the calculation. The reasonableness of detention or conditions of release cannot be assessed without considering the impact of the pandemic. The pandemic carries both an 'overall systemic impact' and also affects more traditional PreTrial release concerns. Because of the pandemic, the community is now endangered by Mr. Toro's detention not his release. The pandemic also disincentivizes flight or non-compliance with any PreTrial release condition. If he is non-compliant or flees, Mr. Toro faces the prospect of being returned to custody and its inherent health risks. If he flees, he risks infection and the unavailability of medical treatment.

1 Facts Underlying The Criminal Charges

Mr. Toro is one of twelve individuals charged after a lengthy wiretap investigation. He is named in Counts 6 and 7 of the 13-count indictment. The first wiretap authorization was in October 2018. Mr. Toro was not mentioned as a Target Subject in any wiretap authorizations until June 2019. He is charged with participating a three-day long conspiracy – June 17-19, 2019 – and one drug transaction on June 17. The government chose to wait until November 8, 2019 to arrest Mr. Toro.

On June 17, 2019, Mr. Toro allegedly arranged to receive eighteen pounds of methamphetamine from one co-defendant (Lopez) and immediately transfer it to another co-defendant (Marin). Mr. Toro's role was limited to facilitation as opposed to a principal in the transaction; the methamphetamine supplier approved the price proposed by the purchaser and tentatively negotiated by Mr. Toro. With regard to the transaction itself, Mr. Toro had transitory

possession of the methamphetamine and the proceeds from its distribution. According to the complaint, Mr. Toro held the methamphetamine for approximately an hour and fifteen minutes; from 7:15 p.m. through 8:30 p.m.

The alleged methamphetamine purchaser was arrested within minutes after leaving Mr. Toro's company and subsequently allowed to 'time-out' of custody. According to the wiretap documents, the alleged methamphetamine supplier cut-off contact with Mr. Toro soon after the purchaser's arrest. Mr. Toro is not charged with any substantive offenses after the alleged June 17, 2019 methamphetamine transaction.

2. 'Traditional' Considerations

Under the Bail Reform Act, pretrial detention is permitted only if the Court finds that no condition of release, or combination of conditions, would reasonably assure the defendant's appearance and the safety of the community. 18 USC 3142(e)(1). "In our society, liberty is the norm, and detention prior to trial or without trial, is the carefully limited exception". *United States v.*Salerno, 481 U.S. 739, 755 (1987). Any doubts about the propriety of release should be resolved in favor of the defendant. *U.S. v. Townsend*, 897 F.2d 989, 994 (9th Cir. 1990).

PreTrial Services has concluded that concerns about danger to the community can be overcome and also stated that a significant bond and a suitable third-party custodian would be essential to mitigate the risk of non-appearance. As detailed below, those conditions have been satisfied.

A. Flight

1. Background

Mr. Toro is sixty-two years old. He has lived in the Fresno area since 1976. His four adult children, ten grandchildren, and a sister all live in the Fresno area. A brother lives in Mexico and his parents are deceased. His proposed third-party custodian(s) are his son Luis Acosta and his daughter Monica Acosta. Monica will allow Mr. Toro to live in her Fresno home. Mr. Acosta is legally entitled to live and work in the United States. [7]

2. Third Party Custodian

Ms. Monica Acosta, the defendant's daughter, is a suitable third-party custodian[8]. She is employed by the Fresno County Superior Court. She has a stable home life and has prepared a room to accommodate her father. Ms. Acosta did suffer a felony conviction for possession of

[7] Mr. Toro's 'green card' has expired but the parties agree that his legal status as a lawful permanent resident able to reside and work in the United States remains. *Kurzban, I.(2018).* Immigration Law Sourcebook.16th ed. American Immigration Council, p. 1408. "Permanent resident card ("green card"), but not LPR status, expires every 10 years and a replacement card must be sought."

If convicted, Mr. Toro is potentially subject to deportation but his immigration status is irrelevant to this Court's release determination. Immigration status is not an enumerated factor in 18 USC 3142(g). If someone does not have lawful status, alienage may be taken into account but is not dispositive. *U.S. v. Santos-Flores*, 794 F.3d 1088, 1090 (9th Cir. 2015). Even whether or not the defendant is subject to an immigration detainer is not a proper consideration for release. *U.S. v. Diaz-Hernandez*, _ F.3d _ C.A. 19-50336 (9th Cir. November 19, 2019). Detention of criminal defendants and detention of removable aliens are separate functions, serving separate purposes and performed by different authorities. *U.S. v. Vasquez-Benitez*, 919 F.3d 546, 552 (D.C. Cir 2019).

[8] Before requesting Mr. Toro's release due to COVID-19 concerns, counsel consulted with Monica Acosta. She verified counsel's recollection that her father suffers from diabetes and added that he also suffers from high blood pressure and cholesterol. She confirmed that there is a room ready for Mr. Toro at her home and she remains willing to post vehicles as security.

marijuana for sale in 2000. More importantly, that conviction was expunged in late March 2015 long after Ms. Acosta's two-year term of probation was successfully completed.

3. Pledged Security

.Mr. Toro's daughters' have limited financial resources but are willing to pledge their vehicles as security for his release[9]. Those vehicles are:

Vehicle	Owner	Approximate value – private party sale
2010 Honda Accord	Rosalinda Acosta	$7300.
2102 Nisan Altima	Rosalinda Acosta	$6900.
2011 Honda Accord	Monica Acosta	$8,000. before salvage title adjustment

One of the three proffered vehicles has 'Salvage Titles'. Defense counsel acknowledges that a salvage title reduces a vehicle's marketability/value but also notes the vehicle retains some value - as demonstrated by Ms. Acosta's purchase of a salvage title vehicle. The vehicle is also valuable and important to Ms. Acosta for transportation. The PreTrial Services officer assigned to Mr. Toro's case advised counsel that the PreTrial Service's policy is to disregard 'salvage title' vehicles proffered as security. A blanket refusal to accept a 'Salvage Title' vehicle as security for release is constitutionally unacceptable; that it is arbitrary, violates the rights to bail and due process, and has a disparate, discriminatory impact on the economically disadvantaged.

[9] Ms. Acosta's vehicle is registered to her spouse and PreTrial Services has confirmed the spouse's willingness to post the vehicle.

4. Mr. Toro's Personal Characteristics- Flight

Mr. Toro has an extensive employment history as a restaurant cook. Several months before his arrest he sold a restaurant he owned. Before the COVID-19 outbreak, Mr. Toro was confident that he could obtain employment upon his release.

There has been a suggestion that Mr. Toro is a flight risk because has visited Mexico in the past and has relatives that live in Mexico. Those contentions would apply to any first-generation immigrant and have limited weight at best. In his PreTrial Services interview, Mr. Toro readily acknowledged travel to Mexico. He listed visits in 1989, 1991, and 1998; with two of the three approximately a month in duration. PreTrial Services had some concern because Monica Acosta reported an additional Mexico trip - a cruise in 2009. Mr. Toro's omission of that trip is attributable to a failure of recollection as opposed to intentional concealment or deception. Although closer in time, the 2009 trip was relatively insignificant compared to the lengthy visits described by Mr. Toro.

PreTrial Services also expressed concern about the passport supposedly used by Mr. Toro in 2009. As it turns out, Mr. Toro used his green card as opposed to a passport. Monica Acosta advised counsel that she would bring that passport to Court. She also advised that she invited Mr. Toro on a more recent cruise (in the past year or two) and he declined, stating that his passport had expired. When Ms. Acosta searched for the 'passport' she found Mr. Toro's green card (now expired) instead.

Mr. Toro acknowledged frequent gambling along with alcohol and cocaine use while gambling. Those issues can be addressed through PreTrial release conditions.

5. Conclusion-Flight

PreTrial Services properly found that the following mitigating factors applied to any risk of flight by Mr. Toro; he is a long time California resident with extensive family and financial ties to California; he has a suitable residence; no history of mental health disorders; and is willing to participate in substance abuse counseling and location monitoring. Mr. Toro should not be detained as a flight risk.

B. Danger

Even before the COVID-19 pandemic, PreTrial Services considered the danger issue and concluded that conditions - significant bond and a suitable third-party custodian - could be fashioned to address any risk. Mr. Toro's criminal history is not significant. His only conviction was thirty years ago; a 1989 misdemeanor battery conviction[10]. Mr. Toro's current status as a federally indicted drug defendant is not likely to encourage drug traffickers to seek his assistance in future trafficking.

The defense acknowledges that the amount of methamphetamine involved in this offense – eighteen pounds – and the alleged proceeds - $38,000 – were significant. However, Mr. Toro's alleged role was a facilitator as opposed to a principal. After the June 17 transaction, the government chose to leave Mr. Toro at liberty until November 8. The government also acknowledged that the alleged methamphetamine supplier cut ties with Mr. Toro shortly after the purchaser's June 17 arrest. Co-defendant Marin, who purchased the methamphetamine has been released from custody on a $100,000 property bond. Undersigned counsel is personally aware

[10] Discovery materials indicate that in 2005, Mr. Toro was a passenger in a vehicle which was stopped on I-15 in Nevada. Approximately $305,000 cash was seized from the vehicle. No charges were brought.

that Marin has an extensive criminal history including a federal prison term and several state prison terms.

PreTrial Services properly concluded that Mr. Toro should not be detained as a danger and this Court should follow that recommendation.

Conclusion

COVID-19 has radically altered the factors which this court must consider in deciding whether to detain or release Mr. Toro. Mr. Toro presented significant arguments favoring his release before this national crisis. Scientific evidence establishes the risk to Mr. Toro and the community if detention continues. To put this matter in the starkest, most realistic terms, a realistic estimate is a 10% likelihood that Mr. Toro will die within the next twelve weeks if he remains in custody. There is a near certainty that he will become infected with COVID-19 and require medical care if he remains in custody. Release should be ordered immediately. Mr. Toro will accept any and all conditions the Court chooses to impose.

Dated: March 23, 2020

Respectfully submitted,

/s Kevin Rooney
KEVIN P. ROONEY
Attorney for defendant
ARMANDO ACOSTA TORO

Declaration for Persons in Detention and Detention Staff
COVID-19

Chris Beyrer, MD, MPH
Professor of Epidemiology
Johns Hopkins Bloomberg School of Public Health
Baltimore, MD

I, Chris Beyrer, declare as follows:

1. I am a professor of Epidemiology, International Health, and Medicine at the Johns Hopkins Bloomberg School of Public Health, where I regularly teach courses in the epidemiology of infectious diseases. This coming semester, I am teaching a course on emerging infections. I am a member of the National Academy of Medicine, a former President of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. I have been active in infectious diseases Epidemiology since completing my training in Preventive Medicine and Public Health at Johns Hopkins in 1992.
2. I am currently actively at work on the COVID-19 pandemic in the United States. Among other activities I am the Director of the Center for Public Health and Human Rights at Johns Hopkins, which is active in disease prevention and health promotion among vulnerable populations, including prisoners and detainees, in the US, Africa, Asia, and Latin America.

The nature of COVID-19

3. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the WHO. Cases first began appearing sometime between December 1, 2019 and December 31, 2019 in Hubei Province, China. Most of these cases were associated with a wet seafood market in Wuhan City.
4. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
5. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.3 to 3.5%, which is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.
6. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate is higher in men, and varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardio-vascular disease, respiratory disease, diabetes, and immune compromise.
7. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS) which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical

ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and parts of China.

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 100 countries and all continents, heavily affected countries include Italy, Spain, Iran, South Korea, and increasingly, the US. As of today, March 16th, 2020, there have been 178,508 confirmed human cases globally, 7,055 known deaths, and some 78,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.

9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.

12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase community rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.

13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.

14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities.

15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff.

16. In addition to the nature of the prison environment, prison and jail populations are also at additional risk, due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death.

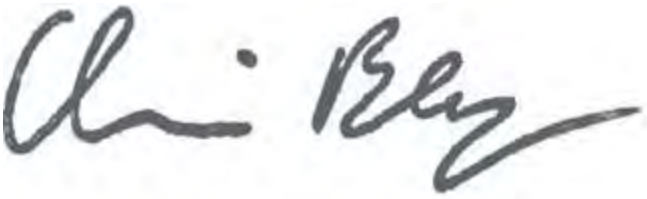
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

18. Pre-trial detention should be considered only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, should be prioritized for release. Immigrants awaiting decisions on their removal cases who are not a flight risk can be monitored in the community and should be released from immigration detention centers. Older inmates and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) should be considered for release.

19. Given the experience in China as well as the literature on infectious diseases in jail, an outbreak of COVID-19 among the U.S. jail and prison population is likely. Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole.

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

Executed this 16th day of March, 2020.



Professor Chris Beyrer[1]

[1] These views are mine alone; I do not speak for Johns Hopkins University or any department therein.

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DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a novel zoonotic coronavirus that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of March 12, 2020, there are over 140,000 confirmed cases of COVID-19. COVID-19 has caused over 5,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

7. The COVID-19 virus can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

8. There is no vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

9. COVID-19 is known to be spreading in the Seattle, Washington-area community. As of March 11, 2020 there are 270 confirmed cases of COVID-19 (an increase of 36 from March 10, 2020) and twenty-seven deaths from COVID-19 in the Seattle area. This

represents the largest known outbreak in the United States, and one the largest known outbreaks in the world as of March 12, 2020.

10. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

11. Based on the recovered genomes of the virus from the community analyzed by the Nextstrain project run by Dr. Trevor Bedford of the Fred Hutchinson Cancer Research Center in Seattle, it is known that the infection is being shared from person to person in and around Seattle. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. The strain of virus spreading in the Seattle area is genetically related to the strain of virus that spread readily on the cruise ships.

12. The COVID-19 outbreak in Seattle has resulted in the need for unprecedented public health measures, including multiple efforts to facilitate and enforce social distancing. These include encouraging employees to work from home, bans of gathering of more than 250 people, closure of schools, closure of the University of Washington campus in Seattle, limitations of visitation to skilled nursing facilities, and cancellation of major public events. Individuals have been asked to delay or cancel health care procedures in order to free up capacity within the system.

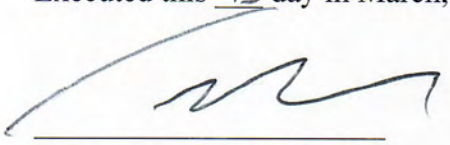
13. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers, particularly when residents cannot engage in proper hygiene and isolate themselves from infected residents or staff.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting,

such as an immigration detention center, with limited access to adequate hygiene facilities and exposure to potentially infected individuals from the community are at grave risk of severe illness and 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 13th day in March, 2020 in Ann Arbor, Michigan.



Dr. Jonathan Louis Golob

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.

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 132,000 people have been diagnosed with COVID-19 around the world and 4,947 have died.[2] In the United States, about 1,700 people have been diagnosed and 41 people have died thus far.[3] 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., the elderly or those 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.

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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] See https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd, accessed March 13, 2020.

[3] See https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1, accessed March 13, 2020.

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. At least one nursing home in the Seattle area has had cases of COVID-19 and has been quarantined.

9. The Seattle metropolitan area, hit hard by COVID, is the epicenter of the largest national outbreak at this time. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the immigration detention facility in Tacoma, Washington. Immigration courts and the ICE field office in Seattle have already closed this month due to staff exposure to COVID-19.

10. 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.

11. Immigration detention facilities are enclosed environments, much like the cruise ships 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.

12. 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.

13. 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. 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.

14. 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.

15. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from NWDC 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 the Pierce County or Washington State Department of Health.

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

Executed this *14th* day in March, 2020 in New York City, New York.

Robert B. Greifinger, M.D.

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

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

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

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

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

5. I am being paid $1,000 for my time reviewing materials and preparing this report.

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

II. Heightened Risk of Epidemics in Jails and Prisons

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

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

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

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

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

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

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

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

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

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

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

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

[1] *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

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

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

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

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

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

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

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

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

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

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.
[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext
[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.
[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice*: *New Jersey, Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.

26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

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

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

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

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

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

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

32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.

38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.

39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.

40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

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

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

March 15, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

EXHIBIT A

CURRICULUM VITAE

Date of Revision:	November 20, 2019
Name:	Jaimie Meyer, MD, MS, FACP
School:	Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
MD, University of Connecticut School of Medicine 2005
MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008	Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
2008 - 2011	Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
2008 - 2012	Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
2010 - 2012	Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
2012 - 2014	Instructor, AIDS, Yale School of Medicine, New Haven, CT
2014 - present	Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
2015 - 2018	Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
AB of Internal Medicine, Infectious Disease, 10-2010
AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018	NIH Center for Scientific Review, Selected as Early Career Reviewer
2017	Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
2016	American College of Physicians, Fellow
2016	NIH Health Disparities, Loan Repayment Award Competitive Renewal
2016	AAMC, Early Career Women Faculty Professional Development Seminar
2014	NIH Health Disparities, Loan Repayment Program Award
2014	NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
2014	International Women's/Children's Health & Gender Working Group, Travel Award
2014	Patterson Trust, Awards Program in Clinical Research
2013	Connecticut Infectious Disease Society, Thornton Award for Clinical Research
2011	Bristol Myers-Squibb, Virology Fellows Award

2006	NY Columbia Presbyterian, John N. Loeb Intern Award
2005	American Medical Women's Association, Medical Student Citation
2005	Connecticut State Medical Society, Medical Student Award
2000	Dartmouth College, Hannah Croasdale Senior Award
2000	Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University

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

Grants/Clinical Trials History:

Current Grants

Agency:	Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#:	2019-20 Pilot Project Awards
Title:	Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.:	Tiara Willie
Role:	Principal Investigator
Percent effort:	2%
Direct costs per year:	$29,993.00
Total costs for project period:	$29,993.00
Project period:	7/11/2019 - 7/10/2020

Agency:	SAMHSA
I.D.#:	H79 TI080561
Title:	CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role:	Principal Investigator
Percent effort:	20%
Direct costs per year:	$389,054.00
Total costs for project period:	$1,933,368.00
Project period:	11/30/2018 - 11/29/2023

Agency:	Gilead Sciences, Inc.
I.D.#:	Investigator Sponsored Award, CO-US-276-D136
Title:	Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role:	Principal Investigator
Percent effort:	8%
Direct costs per year:	$81,151.00
Total costs for project	

period:	$306,199.00
Project period:	6/19/2018 - 1/31/2020
Agency:	NIDA
I.D.#:	R21 DA042702
Title:	Prisons, Drug Injection and the HIV Risk Environment
Role:	Principal Investigator
Percent effort:	22%
Direct costs per year:	$129,673.00
Total costs for project period:	$358,276.00
Project period:	8/1/2017 - 7/31/2020
Agency:	Doris Duke Charitable Foundation
I.D.#:	Clinical Scientist Development Award
Title:	Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Role:	Principal Investigator
Percent effort:	27%
Direct costs per year:	$149,959.00
Total costs for project period:	$493,965.00
Project period:	7/1/2017 - 6/30/2020

Past Grants

Agency:	NIDA
I.D.#:	K23 DA033858
Title:	Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
Role:	Principal Investigator
Percent effort:	75%
Direct costs per year:	$149,509.00
Total costs for project period:	$821,147.00
Project period:	7/1/2012 - 11/30/2017
Agency:	Robert Leet & Clara Guthrie Patterson Trust
I.D.#:	R12225, Award in Clinical Research
Title:	Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$75,000.00

Total costs for project period:	$75,000.00
Project period:	1/31/2014 - 10/31/2015

Agency:	Bristol-Myers Squibb
I.D.#:	HIV Virology Fellowship Award
Title:	Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$34,390.00
Total costs for project period:	$34,390.00
Project period:	12/1/2011 - 11/30/2012

Pending Grants

Agency:	NIMH
I.D.#:	R01 MH121991
Title:	Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
P.I.:	Sullivan, Tami
Role:	Principal Investigator
Percent effort:	30%
Direct costs per year:	$499,755.00
Total costs for project period:	$4,148,823.00
Project period:	1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:

International/National

2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"

2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"

2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"

2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"

2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"

2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"
2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"
2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"
2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"
2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:

International/National

2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"
2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"
2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"
2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"
2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"
2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""
2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"
2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"
2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"
2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

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

2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"

2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"

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

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

2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers

2019 - present Reviewer, Yale DCFAR Pilot Projects

2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)

2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

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

Reviewer

2019 - present Reviewer, JAIDS

2012 - present Reviewer, Addiction Sci and Clin Pract

2012 - present Reviewer, Addictive Behav Reports

2012 - present Reviewer, AIDS Care

2012 - present Reviewer, Social Science and Medicine

2012 - present Reviewer, SpringerPlus

2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy

2012 - present Reviewer, Women's Health Issues

2012 - present Reviewer, Yale Journal of Biology and Medicine

2012 - present Reviewer, AIMS Public Health

2012 - present Reviewer, American Journal on Addictions

2012 - present Reviewer, American Journal of Epidemiology

2012 - present Reviewer, American Journal of Public Health

2012 - present Reviewer, Annals Internal Medicine

2012 - present Reviewer, BMC Emergency Medicine

2012 - present Reviewer, BMC Infectious Diseases

2012 - present Reviewer, BMC Public Health

2012 - present Reviewer, BMC Women's Health

2012 - present Reviewer, Clinical Infectious Diseases
2012 - present Reviewer, Critical Public Health
2012 - present Reviewer, Drug and Alcohol Dependence
2012 - present Reviewer, Drug and Alcohol Review
2012 - present Reviewer, Epidemiologic Reviews
2012 - present Reviewer, Eurosurveillance
2012 - present Reviewer, Health and Justice (Springer Open)
2012 - present Reviewer, International Journal of Drug Policy
2012 - present Reviewer, International Journal of Prisoner Health
2012 - present Reviewer, International Journal of STDs and AIDS
2012 - present Reviewer, International Journal of Women's Health
2012 - present Reviewer, JAMA Internal Medicine
2012 - present Reviewer, Journal of Family Violence
2012 - present Reviewer, Journal of General Internal Medicine
2012 - present Reviewer, Journal of Immigrant and Minority Health
2012 - present Reviewer, Journal of International AIDS Society
2012 - present Reviewer, Journal of Psychoactive Drugs
2012 - present Reviewer, Journal of Urban Health
2012 - present Reviewer, Journal of Women's Health
2012 - present Reviewer, Open Forum Infectious Diseases
2012 - present Reviewer, PLoS ONE
2012 - present Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

2016 - present Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians

2016 - present Fellow, American College of Physicians
2013 - 2016 Member, American College of Physicians

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine

2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School

2013 - present Mentor, Women in Medicine at Yale Mentoring Program

2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS

2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

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2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. Journal Of Immigrant And Minority Health / Center For Minority Public Health 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. AIDS And Behavior 2013, 17 Suppl 2:S118-27.

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7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. International Journal Of Prisoner Health 2013, 9:124-41.
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11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. JAMA Internal Medicine 2014, 174:721-9.
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18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. AIDS Care 2018, 30:1282-1289.
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Chapters, Books, and Reviews

29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. Drug And Alcohol Dependence 2010, 112:178-93.
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32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. Infectious Disease Reports 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. Sexually Transmitted Infections 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award). Oxford University Press 2015. ISBN 9780199360574.
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Peer-Reviewed Educational Materials

43. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014
44. United Nations Office on Drugs and Crime. Vienna, Austria

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. Journal Of General Internal Medicine 2014, 29:1164.
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Case Reports, Technical Notes, Letters

48. **Paul J**. Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
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Scholarship In Press

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

Declaration of Dr. Marc Stern

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I also have considerable familiarity with the immigration detention system. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I have also served as a consultant to Human Rights Watch in their preparation of two reports on health-related conditions of confinement in ICE detention facilities. In those capacities, I have visited and examined more than 20 ICE detention facilities and reviewed hundreds of records, including medical records and detention death reviews of individuals in ICE detention. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease and has reached pandemic status. At least 132,758 people around the world have received confirmed diagnoses of COVID 19 as of March 13, 2020, including 1,629 people in the United States. At least 4,955 people have died globally as a result of COVID-19 as of March 13, 2020, including 41 in the United States. These numbers will increase, perhaps exponentially.

3. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. The only way to control the virus is to use preventive strategies, including social distancing.

4. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that.

5. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

6. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.

7. Detention facilities are congregate environments, i.e. places where people live and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. This therefore presents an increased danger for the spread of COVID-

19 if and when it is introduced into the facility. To the extent that detainees are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, the risks of spread are greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in another congregate environment: nursing homes and cruise ships.

8. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in detention facilities, placing people at risk, especially when the number of detainees is high.

9. For detainees who are at high risk of serious illness or death should they contract the COVID-19 virus, release from detention is a critically important way to meaningfully mitigate that risk. Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff such that they can continue to ensure the safety of detainees.

10. The release of detainees, especially those with increased health-related vulnerability, also supports the broader community because carceral and detention settings, regardless of the level of government authorities that oversee them, are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a Federal immigration detention center slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.

11. As a correctional public health expert, I recommend release of eligible individuals from detention, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19.

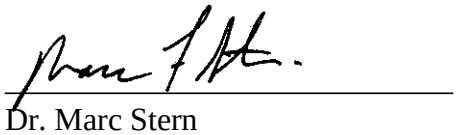
12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the detention center, either among staff or detainees. In the event of this occurring, and eligible detainees being quarantined or isolated due to possible exposure to the virus, I recommend that the detainee(s) be tested for the virus if testing is available. Armed with the results of that test if it is available, or in the absence of other instructions from the health authority of the municipality to which they will be returning or the Washington State public health authority, those who can easily return to a home without exposure to the public, should be released to that home for continued quarantine or isolation for the appropriate time period. All others can be released to appropriate housing as directed or arranged in coordination with the relevant health authority.

13. I have reviewed Plaintiffs' complaint and on the basis of the claims presented, conclude that Plaintiffs have underlying medical conditions that increase the risk of serious illness or death if exposed to COVID-19. Due to the risks caused by the congregate environment in immigration

detention, compounded by the marked increase in risk conferred by their underlying medical conditions, I recommend their release.

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

Executed this __15th___ day in March, 2020 in Tumwater, Washington.



Dr. Marc Stern

OFFICE OF THE GOVERNOR

March 18, 2020

The Honorable Donald J. Trump
White House
1600 Pennsylvania Avenue, NW
Washington, D.C.

Dear Mr. President,

I write to respectfully request you immediately deploy the USNS Mercy Hospital Ship to be stationed at the port of Los Angeles through September 1, 2020, to help decompress our current health care delivery system in Los Angeles region in response to the COVID-19 outbreak.

As you know, California has been disproportionately impacted by repatriation efforts over the last few months. Our state and health care delivery system are significantly impacted by the rapid increase in COVID-19 cases. In the last 24 hours, we had 126 new COVID-19 cases, a 21 percent increase. In some parts of our state, our case rate is doubling every four days. Moreover, we have community acquired transmission in 23 counties with an increase of 44 community acquired infections in 24 hours. We project that roughly 56 percent of our population—25.5 million people—will be infected with the virus over an eight week period.

This resource will help decompress the health care delivery system to allow the Los Angeles region to ensure that it has the ability to address critical acute care needs, such as heart attacks and strokes or vehicle accidents, in addition to the rapid rise in COVID-19 cases. The population density in the Los Angeles Region is similar to New York City, will be disproportionately impacted by the number of COVID-19 cases.

I would ask that the US Navy coordinate with my Office of Emergency Services, through the Defense Coordinator Officer to rapidly deploy this asset.

I thank you for your partnership and look forward to our continued discussion.

Sincerely,

Gavin Newsom
Governor

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

If You Are at Higher Risk

Who is at higher risk?

Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness. This includes:

- **Older adults**
- **People who have serious chronic medical conditions** like:
  - Heart disease
  - Diabetes
  - Lung disease

Get ready for COVID-19 now

Take actions to reduce your risk of getting sick

If you are at higher risk for serious illness from COVID-19 because of your age or because you have a serious long-term health problem, it is extra important for you to take actions to reduce your risk of getting sick with the disease.

- Stock up on supplies.
- **Take everyday precautions** to keep space between yourself and others.
- When you go out in public, keep away from others who are sick, limit close contact and wash your hands often.
- **Avoid crowds** as much as possible.
- **Avoid cruise travel** and non-essential air travel.
- **During a COVID-19 outbreak in your community, stay home** as much as possible to further reduce your risk of being exposed.

Have supplies on hand

- **Contact your healthcare provider to ask about obtaining extra necessary medications** to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home for a prolonged period of time.
- If you cannot get extra medications, consider using mail-order for medications.
- **Be sure you have over-the-counter medicines and medical supplies** (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
- **Have enough household items and groceries** on hand so that you will be prepared to stay at home for a period of time.

See also: Get Your Home Ready

Take everyday precautions

Avoid close contact with people who are sick.

Take everyday preventive actions:

- Clean your hands often
- **Wash your hands often** with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
- If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
- **To the extent possible, avoid touching high-touch surfaces in public places** – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
- Wash your hands after touching surfaces in public places.
- **Avoid touching your face,** nose, eyes, etc.
- **Clean and disinfect** your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones)
- **Avoid crowds,** especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
- **Avoid all non-essential travel** including plane trips, and especially avoid embarking on cruise ships.

See also: Protect Yourself

If COVID-19 is spreading in your community

Take extra measures to put distance between yourself and other people to further reduce your risk of being exposed to this new virus.

- **Stay home** as much as possible.
- **Consider ways of getting food brought to your house** through family, social, or commercial networks

If a COVID-19 outbreak happens in your community, it could last for a long time. (An outbreak is when a large number of people suddenly get sick.) Depending on how severe the outbreak is, public health officials may recommend community actions to reduce people's risk of being exposed to COVID-19. These actions can slow the spread and reduce the impact of disease.

Have a plan for if you get sick

- **Consult with your health care provider** for more information about monitoring your health for symptoms suggestive of COVID-19.
- **Stay in touch with others by phone or email.** You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
- **Determine who can care for you** if your caregiver gets sick.

Watch for symptoms and emergency warning signs

- **Pay attention for potential COVID-19 symptoms** including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
- **If you develop emergency warning signs for COVID-19 get medical attention immediately.** In adults, emergency warning signs*:
  - Difficulty breathing or shortness of breath
  - Persistent pain or pressure in the chest
  - New confusion or inability to arouse
  - Bluish lips or face

*This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

What to do if you get sick

- **Stay home and call your doctor.**
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

> **See also:** What to Do If You Are Sick

What others can do to support older adults

Community support for older adults

- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
  - Many of these individuals live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.
- **Long-term care facilities should be vigilant** to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and caregiver support

- **Know what medications your loved one is taking** and see if you can help them have extra on hand.
- **Monitor food and other medical supplies** (oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- **Stock up on non-perishable food** to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

More info

Prevention and Treatment

Get Your Household Ready

What to Do if You are Sick

COVID-19: What Older Adults Need to Know

Jay Butler, Deputy Director for Infectious Diseases at CDC, describes preventative measures to help protect older adults from COVID-19.

AARP's Coronavirus Information Tele-Town Hall

CDC and other federal experts presented at an AARP tele-town hall event held on March 10, 2020 discussing prevention and care for older adults.

Page last reviewed: March 12, 2020

FRESNO COUNTY SHERIFF'S OFFICE
2200 Fresno St., Fresno CA 93721 - (559) 600-8400

All Inmate Visits Currently Suspended at Fresno County Jails. For more information, click here.

MEDIA RELATIONS

Eleven Cases of Mumps Confirmed in Fresno County Jail

On Thursday, the Fresno County Sheriff's Office and the Fresno County Department of Health received the results of tests recently taken to determine the possible presence of the Mumps virus in the Fresno County Jail. The State of California confirmed 11 inmates tested positive for Mumps.

The Sheriff's Office first became aware on January 23rd that the Mumps virus might be present in the North Annex Jail. At that time, jail staff and our jail medical provider, Wellpath, put several precautionary measures in place, which continue to remain in effect. This includes the implementation of quarantining inmates in specific areas to ensure there is no additional spread of any potential health-related illness. Approximately 300 inmates are affected by the quarantine. All inmates are being assessed daily and immunizations are being offered to both inmates and jail staff.

Mumps is a viral infection that primarily affects saliva-producing (salivary) glands that are located near your ears an may lead to swelling. People at risk of contracting Mumps are those who are not vaccinated and expose themselves to close-contact settings such as schools, college campuses and correctional facilities. Signs and symptoms are typically known to develop 12 – 25 days after infection. Mumps can be serious, but most people with mumps recover completely within two weeks.

To combat the Mumps virus, a Measles-Mumps-Rubella (MMR) vaccine is available. A person with two doses of MMR vaccine has about an 90% reduction in risk for mumps; a person with one dose has an 80% reduction in risk for mumps.

If you become infected with Mumps, reduce the spread by avoiding contact with people for five days after your salivary glands begin to swell, since this is when you are most contagious. It is also important for EVERYONE to wash their hands often.

Inmates in the quarantined area are currently being allowed one visitation per week.

The booking and release process is not being impacted by the virus. However, Wasco State Prison is not accepting any sentenced inmates into its facility until the quarantine is lifted.

All inmates going through the release process are given educational health materials.

All business at the Fresno Superior Courthouse is currently functioning normally. At this time, the court is not calling any of the quarantined inmates to the courthouse until the quarantine is lifted.

There is an ongoing investigation to try and determine who the original inmate is that contracted the Mumps virus.

Details

Written by Botti, Tony | *Category: Media Relations* | *Published: 30 January 2020* | *Hits: 414*

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- The Fresno Bee
- Univision 21

CRIME

Quarantine shrinking, inmates coming to court despite mumps in jail

Dr. Nevin also said any mumps quarantine wouldn't need to last more than five days and questioned why the sheriff's office would release quarantined inmates.

By Corin Hoggard

Tuesday, February 11, 2020

FRESNO, Calif. (KFSN) -- The mumps quarantine at the Fresno County jail is slowly shrinking, but attorneys claim the county's response reveals how poorly it would handle a more serious illness.

The sheriff's office told Action News the quarantine is still in effect, but we've learned they've let about 200 people out of quarantine.

Former Fresno Unified bus driver Jeffrey Sipes isn't one of them.

He should've gone on trial at the end of January, but he hasn't attended his last three court dates even though he's been in jail the whole time.

"We've had a lot of interruptions based upon this quarantine that has been imposed for no good reason," said Schweitzer, who represents Sipes.

The jail keeps Sipes in a pod where a mumps outbreak was suspected a couple weeks ago.

He finally came to court Monday, but a judge wouldn't let us record video of his appearance.

A sheriff's deputy wearing a protective white face mask and blue rubber gloves wheeled him into court wearing a face mask and rubber gloves of his own. Deputies wouldn't let him have water because he's not allowed to remove the mask.

Sipes' attorney has argued the courts would violate his right to a speedy trial if they didn't get his trial going by Tuesday.

He got a report from a Johns Hopkins-trained epidemiologist, Dr. Remington Nevin, saying the jail didn't need to cast such a wide net with its quarantine.

For example, he says the Centers for Disease Control does not recommend quarantine for people with a vaccination history and no symptoms of the mumps.

"What we're seeing here in Fresno County is a very improper procedure which gives us a lot of concern about what would happen if there really was something dangerous," Schweitzer said.

Dr. Nevin also said any mumps quarantine wouldn't need to last more than five days and questioned why the sheriff's

A previous statement from the jail said "the release process is not being impacted by the virus."

"I hate to speak out of school, but it tells me the quarantine is a bunch of bologna," Schweitzer said.

The county's assistant public health director told us the CDC recommendations don't necessarily apply in places like jails, where people live in very close proximity to each other.

David Luchini said they have to do their best to prevent the spread, so the quarantine is the best possible practice.

And he pointed out they've gotten a new, twelfth mumps diagnosis since they confirmed 11 cases right after the original quarantine. They've gotten no new cases for several days now.

The presiding judge in Fresno County issued an order a couple weeks ago saying the outbreak was a good enough reason to

exposure.

"On Monday, a judge made a decision to allow quarantined inmates into the courthouse to attend hearings," said Tony Botti. "However, this will be done systematically. A deputy/correctional officer will individually escort the inmate from the jail to court and then back to jail. They will never be placed into a holding cell in order to reduce possible contamination of an area. The inmate will be wearing a mask during this entire procedure.

As for the jail releasing quarantined inmates back into the community after serving their time or posting bond, we have no choice but to do so. We cannot legally hold a person in jail if their sentence is complete or they make bail. Everyone released is given health material so they are educated about good hygiene practices and what to be aware of in terms of symptoms of the mumps."

Quarantined defendants like Sipes started trickling in, but almost 400 of them are still in isolation.

Report a correction or typo

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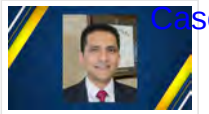
ABC30 Fresno

CRIME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SUPERIOR COURT OF CALIFORNIA, COUNTY OF FRESNO

CENTRAL DIVISION

IN RE MEDICAL QUARANTINE OF FRESNO COUNTY JAIL	Dept. 62 SECOND ORDER FINDING GOOD CAUSE FOR CONTINUANCES BEYOND STATUTORY TIME DUE TO MEDICAL QUARANTINE OF THE FRESNO COUNTY JAIL

On January 28, 2020 the Court was notified by the Fresno County Sheriff's Department of an outbreak of mumps, a contagious viral disease, within the main jail inmate population. "Mumps is a viral illness caused by a paramyxovirus, a member of the rubulavirus family. The average incubation period for mumps is 16 to 18 days, with a range of 12 to 25 days." (https://www.cdc.gov/mumps/hcp.html, last accessed Jan. 30, 2020.)

For this reason the Fresno County Sheriff's Department implemented a quarantine of seven pods in the North Jail. The attached list of inmates are currently under that quarantine, and will not be transported to Court for any future hearing for the du ration of the quarantine.

For those inmates who have time-out dates for either a preliminary hearing or for trial set from January 31, 2020 up to and including February 14, 2020, the Court finds good cause to exceed those time-out dates due to the necessity of the medical

quarantine. (*People v. Tucker* (2011) 196 Cal.App.4th 1313, 1317-1318.)

The Court anticipates that additional orders will be issued regarding the quarantine of inmates and the expected duration of the quarantine, with lists of the specific inmates affected.

The Fresno County Sheriff's Department is directed to submit to this Court a list of all inmates affected by the quarantine, showing their location and JID numbers, as the list of affected inmates changes. The Fresno County Sheriff's Department is further directed to submit to the Court updates as to the expected duration of the quarantine as the expected duration date changes.

DATED this 31st day of January 2020.

Arlan L. Harrell,
Presiding Judge,
Superior Court of California,
County of Fresno

1/28/2020

NAME	FAC-FLR-	JID
ABRIL, GREGORY HUNTER	NJ, 03, 0F, 16	7035972
AGUILAR, JASON THOMAS	NJ, 03, 0F, 64	1208826
ALVARADO, RICHARD EPIFANIO	NJ, 03, 0F, 39	0847372
ANGUIANO, ERIC	NJ, 03, 0F, 40	7031490
BORGES, JONATHAN RAY	NJ, 03, 0F, 06	7014906
BUTLER, CHRISTOPHER BERNARD	NJ, 03, 0F, 02	0991338
CECIL, JEREMY	NJ, 03, 0F, 32	1517944
CHAVEZ, MICHAEL ANGELO	NJ, 03, 0F, 35	1739163
COOK, MICHAEL ADAM	NJ, 03, 0F, 41	7042667
CORONA, ERNEST STEVEN	NJ, 03, 0F, 19	7010370
CORONA, JUAN CARLOS	NJ, 03, 0F, 37	7090234
CORONADO, RICHARD	NJ, 03, 0F, 28	1829666
CRUZ, ALFRED	NJ, 03, 0F, 12	1482761
DAILEY, MOSES LEE ANDREW	NJ, 03, 0F, 59	7048637
DALY, ROGER WAYNE	NJ, 03, 0F, 27	0870705
ESTALA, DOMINGO MARTINEZ	NJ, 03, 0F, 09	0970863
EVANS, CHASE RYAN	NJ, 03, 0F, 56	1187397
EVERETT, CLIFFORD	NJ, 03, 0F, 45	0740221
FLORES, JOEL	NJ, 03, 0F, 25	0191188
FOUQUET, THOMAS RODNEY SHADE	NJ, 03, 0F, 52	0827065
FRANCO, JOE BENNY	NJ, 03, 0F, 26	7100415
FREGOZO, ROBERTO	NJ, 03, 0F, 62	1278753
GARCIA, ROBERT DANIEL	NJ, 03, 0F, 43	1213631
GARZA, EDDIE EDMUND	NJ, 03, 0F, 30	0128156
GARZA, MARCELINO	NJ, 03, 0F, 20	1194321
GOMEZ, IVAN MISAEL	NJ, 03, 0F, 24	7047192
GURROLA, JACOB PASOS	NJ, 03, 0F, 14	1654661
GUTIERREZ, ESTEBAN	NJ, 03, 0F, 42	1167721
GUTIERREZ, WILLIAM E	NJ, 03, 0F, 50	7096715
HARRIS, KURT PAUL	NJ, 03, 0F, 70	1833329
IBARRA, JAVIER TAPIA	NJ, 03, 0F, 67	1816173
JASSO, RALPH ENRIQUE	NJ, 03, 0F, 15	1424691
JIMENEZ, RAYMOND LUIS	NJ, 03, 0F, 03	1585504
JONES, ANDREW DAWAYNE	NJ, 03, 0F, 05	7024719
JONES, VERNON MICHAEL	NJ, 03, 0F, 63	7025260
LARA, ALFRED JOSEPH	NJ, 03, 0F, 48	1174702
LEDESMA, MARTIN ANGEL	NJ, 03, 0F, 38	1351043
LEYVA, MICHAEL ANTHONY	NJ, 03, 0F, 01	1524489
LOPEZ, FILBERTO	NJ, 03, 0F, 18	1110764
LYNCH, CHARLES	NJ, 03, 0F, 29	7098946
MARSHALL, KENNETH ALLEN	NJ, 03, 0F, 13	0511774
MARTINEZ, FREDDIE PERALES	NJ, 03, 0F, 33	1273424
MATUS, ENRIQUE	NJ, 03, 0F, 08	1487120
MEDINA, CHRISTIAN JOEL	NJ, 03, 0F, 44	7059649
MEJIA, ROBERT ROBERT	NJ, 03, 0F, 34	7100422
MOLINA, ENRIQUE SANDOVAL	NJ, 03, 0F, 22	1460337
NARANJO, ABEL	NJ, 03, 0F, 46	7038676
OROZCO, EMILIO	NJ, 03, 0F, 21	1761496
PACK, RANDALL LOYYD	NJ, 03, 0F, 36	7100071
PALOMAR, LUIS EMILIO	NJ, 03, 0F, 11	7085976
PARAMO, SEBASTIAN JUAN	NJ, 03, 0F, 23	7043282
PEREZ, ARTHUR MENDOZA	NJ, 03, 0F, 17	7038286
PONCE, JAIME BRANDON	NJ, 03, 0F, 71	1493506
RAMIREZ-PEREZ, OMAR	NJ, 03, 0F, 55	7009763
RENTERIA, BRANDON ALEX	NJ, 03, 0F, 07	7085474
RIOS, NATHAN JOSE	NJ, 03, 0F, 72	1078977
RODRIGUEZ, JOHN JOSE	NJ, 03, 0F, 53	7029763
SAAVEDRA, JOSE MANUEL	NJ, 03, 0F, 66	1834612

SANCHEZ, JOHN MANUEL	NJ, 03, 0F, 66	6678306
SANDOVAL, CHRISTOPHER	NJ, 03, 0F, 58	7045820
SERVIN, ALFONSO TENA	NJ, 03, 0F, 04	7031926
SERVIS, JOSHUA ALLEN	NJ, 03, 0F, 57	7046552
SMITH, TROY LAMAR	NJ, 03, 0F, 54	1692218
SPENCE, ROBERT EARL	NJ, 03, 0F, 49	7070729
STOREY, DUSTIN ALLEN	NJ, 03, 0F, 51	7012032
TORRES, RAUL	NJ, 03, 0F, 10	7076476
VALDEZ, PAUL	NJ, 03, 0F, 47	1743133
VALENZUELA, JOHNNY GUTIERREZ	NJ, 03, 0F, 68	7046231
VARGAS, RENE MOLINA	NJ, 03, 0F, 60	1360197
WALKER, JAMI DEVIN	NJ, 03, 0F, 61	7073104
WISE, JOSEPH GUY	NJ, 03, 0F, 31	7033156
YBARRA, JULIAN	NJ, 03, 0F, 69	0483409

TOTAL INMATES 72

2

NAME	FAC-FLR-CELL	JID
AGUAYO, EDWARD AARON	NJ, 04, 0B, 13	7091886
ALVARADO, ABRAHAM	NJ, 04, 0B, 16	1824121
ALVARADO, GEORGE ARMANDO	NJ, 04, 0B, 49	7092078
BADILLO, JOSE ALBERTO	NJ, 04, 0B, 54	7095639
BARRAZA, ALFREDO	NJ, 04, 0B, 71	7073884
BECKER, RONALD MICHAEL	NJ, 04, 0B, 60	7090297
BERRY, MICHAEL BEVIN	NJ, 04, 0B, 09	0627441
BISPHAM, CHRISTOPHER LEE	NJ, 04, 0B, 43	7086118
BRACAMONTES, MIGUEL ANGEL	NJ, 04, 0B, 50	0620938
BROWN, REGIS JAEY	NJ, 04, 0B, 47	7082809
BUITRAGO, JOHN MANUEL	NJ, 04, 0B, 70	7052571
CASTELLANOS, DAVID	NJ, 04, 0B, 08	7087056
CERNA, JOSE DAVID	NJ, 04, 0B, 14	7099087
CERVANTEZ, JOHNATHAN JOSEPH	NJ, 04, 0B, 20	7098789
CHILDS, PHILLIP DAVID	NJ, 04, 0B, 68	7098060
CLEAVER, JAMES EUGENE	NJ, 04, 0B, 02	7041405
CORREIA, JOHN MANUEL	NJ, 04, 0B, 37	7020647
DELGADO, CARLOS	NJ, 04, 0B, 10	7031135
FERNANDEZ, JORGE FIDEL	NJ, 04, 0B, 04	7092186
FIMBREZ, ALBERT ISAAC	NJ, 04, 0B, 12	0042669
FLORES, GEORGE	NJ, 04, 0B, 34	0067152
FLORES, JOSEPH	NJ, 04, 0B, 38	1806486
GARCIA, JESSE	NJ, 04, 0B, 59	7058900
GIRON, GUILLERMO	NJ, 04, 0B, 26	7087956
GOHLKE, RASMUS	NJ, 04, 0B, 33	1805878
GOMEZ, ADRIAN RIVERA	NJ, 04, 0B, 45	1595908
GONZALEZ, JUAN MANUEL ARRELLANO	NJ, 04, 0B, 69	7097887
HERING, MICHAEL DEAN	NJ, 04, 0B, 41	7100416
HERNANDEZ, ANDRES	NJ, 04, 0B, 67	7098865
HERNANDEZ, CHRISTOPHER JOHN	NJ, 04, 0B, 52	7097117
HERNANDEZ, MISAEL MARTINEZ	NJ, 04, 0B, 29	7088601
HERNANDEZ, RUBEN	NJ, 04, 0B, 42	1841724
HINOJOSA, FERNANDO ABEL	NJ, 04, 0B, 53	0145500
HURTIG, BRYAN NICHOLAS	NJ, 04, 0B, 22	7007227
IBARRA-NINO, RIGOBERTO	NJ, 04, 0B, 23	7093133
JIMENEZ, MARCOS ALEJANDRO	NJ, 04, 0B, 25	7088312
JIMINEZ, VIRGINIO RUANO	NJ, 04, 0B, 24	1019408
JOHNSON, CARL WAYNE	NJ, 04, 0B, 15	7093785
JOHNSON, KENNETH	NJ, 04, 0B, 32	7079015
JONES, MICHAEL	NJ, 04, 0B, 57	1021709
JONES, STEVEN DALE	NJ, 04, 0B, 35	7039980
LEIJA, MARCUS SIMON	NJ, 04, 0B, 58	7079577
MANN, ERNEST MARK	NJ, 04, 0B, 66	1796357
MARTINEZ, ANTONIO WENSALAO	NJ, 04, 0B, 17	1741541
MATLAK, STEVEN MICHAEL	NJ, 04, 0B, 65	7084382
MORRIS, PHILIP TERRELL	NJ, 04, 0B, 03	7094446
NEWSOME, DEONDREA LEE	NJ, 04, 0B, 39	1349916
NIN, DAVID JAHVE	NJ, 04, 0B, 18	7090538
PEACOCK, PAUL	NJ, 04, 0B, 27	0527103

PENNYCOOK, GEORGE JOSEPH	NJ, 04, 0B, 48	7070326
PORTILLO, HECTOR	NJ, 04, 0B, 61	7022738
PRICE, JUSTIN JAMES	NJ, 04, 0B, 06	7063335
RAMOS, MARTIN PHILLIP	NJ, 04, 0B, 30	7085319
RIVERA, CARLOS JUAREZ	NJ, 04, 0B, 63	1825513
RIVERA, JOSE	NJ, 04, 0B, 21	7062909
SALAS, MANUEL RICHARD	NJ, 04, 0B, 64	7074236
SALDANA, JESUS MARTIN	NJ, 04, 0B, 40	7094305
SANTOS, ANGEL	NJ, 04, 0B, 28	7088717
SIMPKINS, TERRY JAY	NJ, 04, 0B, 19	7099827
SINGH, KARMJIT	NJ, 04, 0B, 01	7094718
SIPES, JEFFREY TODD	NJ, 04, 0B, 46	7082654
TAFOYA, FIDEL ISAAC	NJ, 04, 0B, 44	0382115
TAPIA, MICHAEL ISAAC	NJ, 04, 0B, 55	1192687
THOMAS, ALBERT JAMES	NJ, 04, 0B, 56	7078694
VALDEZ, RAMIRO ISABEL	NJ, 04, 0B, 36	7064349
WILLIAMS, MICAH WAYNE	NJ, 04, 0B, 31	7081441
ZAPATA, AMADOR ANGEL	NJ, 04, 0B, 07	0915709

TOTAL INMATES 67

2

NAME	FAC-FLR-CELL	JID
ADAMS, PRISTON JAMES	NJ, 04, 0D, 51	7022531
ADVINCULA, LISANDRO GIOVANNI	NJ, 04, 0D, 57	7092548
ARELLANO, CHRISTIAN JESUS	NJ, 04, 0D, 61	7082328
BAUTISTA, FRANCISCO	NJ, 04, 0D, 55	7045008
BELL, COREY LEE	NJ, 04, 0D, 71	7079259
BLANCO, JACOB	NJ, 04, 0D, 67	7083223
BYRD, JAMES JOSHUA	NJ, 04, 0D, 45	7016473
CAMPBELL, FRANK EUGENE	NJ, 04, 0D, 49	7092927
CANSECO, ISIDRO MANUEL	NJ, 04, 0D, 46	7099250
CHAVEZ, DANIEL	NJ, 04, 0D, 66	7071611
CIOKEWICZ, JUSTIN W	NJ, 04, 0D, 13	7081699
COOPER, MICHAEL WAYNE	NJ, 04, 0D, 15	0314168
CORTEZ, CHRISTOPHER	NJ, 04, 0D, 21	1345593
CORTEZ-LEIVA, RICARDO ALFREDO	NJ, 04, 0D, 26	7096121
CRUMPLER, AHKEEM JUWAN LUPARKER	NJ, 04, 0D, 40	7053087
DESATOFF, JUSTIN	NJ, 04, 0D, 60	7059807
FISHER-WALTZ, GARY	NJ, 04, 0D, 47	7094067
HERNANDEZ, PRUDENCIO	NJ, 04, 0D, 18	7056176
HIGH, THOMAS	NJ, 04, 0D, 33	1125773
HUNTER, MARCUS ED	NJ, 04, 0D, 23	0235641
JIMENEZ, EDGAR	NJ, 04, 0D, 72	7066445
JONES, DANIEL	NJ, 04, 0D, 06	0111889
LE, DONALD THI	NJ, 04, 0D, 24	1670808
LIRA, EDWARD P	NJ, 04, 0D, 48	1786741
LY, ALEXANDER	NJ, 04, 0D, 34	7094656
MASON, EDWARD WAYNE	NJ, 04, 0D, 02	0131300
MASON, HUNTER JAMES	NJ, 04, 0D, 64	7053631
MCCORMICK, BRANDON AUSTIN	NJ, 04, 0D, 53	7099635
MENDEZ, JOSEPH SCOTT	NJ, 04, 0D, 01	1159015
MORENO, ROGER JOE	NJ, 04, 0D, 62	0107142
MUNOZ, ADAM ALFRED	NJ, 04, 0D, 04	1764073
MURDOCK, JAMES ROBERT	NJ, 04, 0D, 11	1802506
MURPHY, EARL PRENTICE	NJ, 04, 0D, 14	0087750
OVIEDO, ERIC PAUL	NJ, 04, 0D, 37	1357683
PALMORE, CHRISTOPHER BYRON	NJ, 04, 0D, 38	7076929
PATTON, HERMAN	NJ, 04, 0D, 31	0435717
PEREZ, JUAN CARLOS	NJ, 04, 0D, 12	7087306
RAMIREZ, JERONIMO ISMAEL TOMAS	NJ, 04, 0D, 09	7099964
REYES, HERIBERTO	NJ, 04, 0D, 70	7097869
RHOAN, KENNETH JOHN	NJ, 04, 0D, 35	1036299
RIVERA, JOSE LUIS	NJ, 04, 0D, 25	7057839
ROWTON, ANTHONY NICOLE	NJ, 04, 0D, 69	1609837
SAECHAO, CHRISTOPHER SIO	NJ, 04, 0D, 65	7093144
SALAZAR, DANIEL VINCENT	NJ, 04, 0D, 07	7100397
SANTOS, DOMINGO REYES	NJ, 04, 0D, 41	1495515
SCANIO, WADE MICHAEL	NJ, 04, 0D, 58	1749594
SCARBOROUGH, IAN PATRICK	NJ, 04, 0D, 17	7038597
SENSABAUGH, STEVEN DAMIEN	NJ, 04, 0D, 63	7081475
SHELTON, QUINTON JAMES	NJ, 04, 0D, 56	1707603
SMOTHERS, CHRISTOPHER ROBERT	NJ, 04, 0D, 27	7024622
STORY, BRANDON THOMAS	NJ, 04, 0D, 08	7022597

URETA, VICTOR ANTHONY	NJ, 04, 0D, 36	7034604
VACA, NICKY JESUS	NJ, 04, 0D, 10	7038524
VANG, BEE	NJ, 04, 0D, 16	7099883
WALKER, KENNETH	NJ, 04, 0D, 32	1057487
WILSON, STEPHEN KEVIN	NJ, 04, 0D, 05	7088915
WOODALL, TOM LARN	NJ, 04, 0D, 30	7084159
WUNSTELL, AARON J	NJ, 04, 0D, 03	0985342
YANG, KER	NJ, 04, 0D, 39	7091431
TOTAL INMATES	**59**	

2

NAME	FAC-FLR-CELL	JID
MARTINEZ, DANNY GONZALO	NJ, 04, 0E, 03	7097301
MARTINEZ, RAMIRO MARTIN	NJ, 04, 0E, 15	7051244
MOORE, JUSTIN	NJ, 04, 0E, 39	7057342
RAMIREZ, JUAN	NJ, 04, 0E, 27	0835689

TOTAL INMATES 4

NAME	FAC-FLR-CELL	JID
ANDERSON, JUSTIN LEE	NJ, 05, 0A, 31	7025165
ARMSTRONG, NATHANIEL	NJ, 05, 0A, 54	7089448
BAGORIO, BASILIO MERCADC	NJ, 05, 0A, 26	7089339
BEECHER, SUBAHZAI	NJ, 05, 0A, 32	7076500
BISLA, GURMEET SINGH	NJ, 05, 0A, 13	1470285
BLAIR, SCOTTY MITCHEL	NJ, 05, 0A, 11	7056697
CABRERA, ALEJANDRO	NJ, 05, 0A, 60	7096111
CARBAJAL, JOSE JESUS	NJ, 05, 0A, 04	7086953
CERVANTES, DANIEL	NJ, 05, 0A, 47	7056529
CORRALES, MIGUEL ANGEL	NJ, 05, 0A, 72	7087392
CROPPER, RICKY	NJ, 05, 0A, 27	7027873
CUMBRY, JABARRI CAMERON	NJ, 05, 0A, 64	7048387
DELGADO, ISMAEL	NJ, 05, 0A, 63	7100197
DONOHUE, KENNETH	NJ, 05, 0A, 58	7090048
DUARTE-BELTRAN, MARCO L	NJ, 05, 0A, 23	7091492
ELLIS, ROBERT	NJ, 05, 0A, 65	7094107
ESCUTIA, DELVINO BETO	NJ, 05, 0A, 19	1514208
FAAS, CARLOS JOSE	NJ, 05, 0A, 50	7098383
FANE, ANDRE FRANCOIS	NJ, 05, 0A, 56	1766057
FIGUEROA, JOSE JUAN	NJ, 05, 0A, 59	7072106
FINNEY, RANDOLPH	NJ, 05, 0A, 66	7095340
GARCIA, ALVARO	NJ, 05, 0A, 68	1670010
GARCIA, MICHAEL	NJ, 05, 0A, 29	7096592
GILLARD, BRODERICK RAY	NJ, 05, 0A, 22	7092838
GONZALES, PATRICK LEE	NJ, 05, 0A, 57	7098282
HAYDEN, JORDAN CHRISTOP	NJ, 05, 0A, 33	1352801
HILL, BRODRICK JEROME	NJ, 05, 0A, 39	7080603
JAMES, LARRY	NJ, 05, 0A, 41	7087529
JOHN, ROGER	NJ, 05, 0A, 34	7086655
JUAREZ, JULIAN	NJ, 05, 0A, 18	1400234
KENNEDY-WILLIAMS, GAGE A	NJ, 05, 0A, 55	7068769
KOVAL, GARY	NJ, 05, 0A, 08	7098036
LARA, BENJAMIN JORDAN	NJ, 05, 0A, 40	7007147
LEE, KACHAI	NJ, 05, 0A, 09	1720402
LEE, MICHAEL	NJ, 05, 0A, 52	0571958
LOERA, JORGE	NJ, 05, 0A, 12	7094845
LOPEZ CISNEROS, RAFAEL	NJ, 05, 0A, 35	7079886
MA, JONATHAN AYRIS	NJ, 05, 0A, 61	7045957
MANTE, DANIEL ALAN	NJ, 05, 0A, 70	1758416
MARTINEZ, J AUDON	NJ, 05, 0A, 28	1011896
MILLER, MATTHEW ALLEN	NJ, 05, 0A, 37	7088076
MONTENEGRO, MANUEL DE	NJ, 05, 0A, 14	1242070
MOORE, DEMETRIUS	NJ, 05, 0A, 62	7003004
MOORE, TARI	NJ, 05, 0A, 24	7068013
MORENO, CHRISTOPHER	NJ, 05, 0A, 21	7041136
MUNOZ, MARK ANDREW	NJ, 05, 0A, 38	7007113
MURRAY, JAMIE MICHAEL	NJ, 05, 0A, 46	0816868
NEWLAND, GARRETT DREW	NJ, 05, 0A, 69	1833271
ONTIVEROS, JOE THOMAS	NJ, 05, 0A, 49	0548734
RAMIREZ, ANTHONY THOMAS	NJ, 05, 0A, 07	1685616
RODRIGUEZ, ULISSES SERGI	NJ, 05, 0A, 06	7083905

ROJAS-AGUILAR, JUAN PAUL	NJ, 05, 0A, 44	7085273
SANCHEZ, JESSE MONICO	NJ, 05, 0A, 45	7027677
SANTEMA, GERALD JAMES	NJ, 05, 0A, 25	1174072
SAYADETH, CHAMPA	NJ, 05, 0A, 05	1138126
SHEFFLER, TONY LEE	NJ, 05, 0A, 53	0070854
SINGH, KULPREET	NJ, 05, 0A, 17	7058031
TORRES, JUVENTINO CHAVE	NJ, 05, 0A, 02	7070457
VANG, YEE	NJ, 05, 0A, 43	1805551
VELASCO, ISIDORO	NJ, 05, 0A, 01	7000882
VIRDI, AVTAR SINGH	NJ, 05, 0A, 36	1628266
YOUNG, WALTER KEITH	NJ, 05, 0A, 30	1196398

TOTAL INMATES **62**

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NAME	FAC-FLR-CELL	JID
AGUILAR, LUIS IVAN	NJ, 05, 0F, 52	1363001
ARELLANO-MANZO, MICHAEL	NJ, 05, 0F, 32	7053626
ARREOLA, EDDIE RAY	NJ, 05, 0F, 33	7028119
BANDA, PAZ GARCIA	NJ, 05, 0F, 47	1315109
BRUMMETT, JOSEPH	NJ, 05, 0F, 37	7071200
BURCIAGA, RALPH ANTHONY	NJ, 05, 0F, 44	1642488
BYE, JOSEPH PETER	NJ, 05, 0F, 62	1116421
CARDENAS, ANTONIO	NJ, 05, 0F, 69	1424788
CARRION, NICHOLAS ALEXANDER	NJ, 05, 0F, 38	7063666
CARROL, BRIAN	NJ, 05, 0F, 40	1418891
CERNA, NETZAHUALCOYOTL	NJ, 05, 0F, 49	1146971
CHITAY, JOHN	NJ, 05, 0F, 53	1493293
CLARK, JUSTEN ROGER	NJ, 05, 0F, 36	1222682
COLLINS, GREG	NJ, 05, 0F, 17	0130742
CONTRERAS, ANGELO ANTONIO	NJ, 05, 0F, 14	0967149
CORRAL, MICHAEL DAVID	NJ, 05, 0F, 19	0543525
DELEON, GILBERT	NJ, 05, 0F, 41	1481116
DIAZ, ABEL ANTHONY	NJ, 05, 0F, 42	7054820
DORAME, ANDREW ROBERT	NJ, 05, 0F, 03	7097520
ENOS, JOSHUA LELAND	NJ, 05, 0F, 30	1435790
ESCANO, JESSE MOSES	NJ, 05, 0F, 28	7075051
ESPINOZA, FIDEL	NJ, 05, 0F, 64	7050096
ESTRADA, LOUIE RAY	NJ, 05, 0F, 21	0827132
GARCIA, ALEX AUGUST	NJ, 05, 0F, 66	1577587
GONZALES, NATHAN CLAY	NJ, 05, 0F, 15	0636011
GONZALEZ, MICHAEL ANTHONY	NJ, 05, 0F, 11	7018073
GUERRERO, MATEO ANTHONY	NJ, 05, 0F, 59	1746299
HAMLETT, TRENT	NJ, 05, 0F, 10	1824018
HERRERA, OSCAR	NJ, 05, 0F, 61	0384222
JAUREGUI, GABRIEL	NJ, 05, 0F, 58	7072458
JIMENEZ, VICTOR MANUEL	NJ, 05, 0F, 25	1208243
JONES, LARAY MICHAEL	NJ, 05, 0F, 16	1732349
KIDANE, MEHARIE GEBREMICAEL	NJ, 05, 0F, 68	1762320
KIRSCHER, JASON GAMATIAN	NJ, 05, 0F, 07	1140391
LOPEZ, ALEJANDRO	NJ, 05, 0F, 67	7041299
MADRIGAL, GERARDO	NJ, 05, 0F, 13	7085062
MADRIGAL, SILBANO BRAWLEY	NJ, 05, 0F, 65	7091495
MARTINEZ, ALONZO ERIC	NJ, 05, 0F, 43	7058252
MARTINEZ, NOEL JAMES	NJ, 05, 0F, 55	0240952
MCCORVEY, LARRY	NJ, 05, 0F, 01	7059695
MEDFORD, AUSTIN CYRUS	NJ, 05, 0F, 04	7081900
MEJIA, JOSE RAMON	NJ, 05, 0F, 34	7093706
MONTES, BENNIE EVAN	NJ, 05, 0F, 35	7046152
MORALES, EDDIE	NJ, 05, 0F, 31	7059221
NEWTON, SEMAJI LAMONT	NJ, 05, 0F, 57	7069817
PALOMINO, EDWARD	NJ, 05, 0F, 23	1195835
PEREZ, MARCOS	NJ, 05, 0F, 50	0145357
PEREZ, PATRICK SHAWN	NJ, 05, 0F, 63	1746318
PINEDA, JOSEPH JONATHAN	NJ, 05, 0F, 54	1433461
QUINTANA, JOHNNY	NJ, 05, 0F, 27	0074806
RAMIREZ, FLORENCIO	NJ, 05, 0F, 46	1403430

REYES, NICKY CRUZ	NJ, 05, 0F, 22	7023372
RIDDLE, JUSTIN DWAYNE	NJ, 05, 0F, 09	7000871
RODRIGUEZ, STEVEN RAY	NJ, 05, 0F, 29	7031479
ROMER, JOSEPH PATRICK	NJ, 05, 0F, 72	7076356
ROMERO, ALBERTO	NJ, 05, 0F, 60	0525683
ROMERO, ROY ALBERT	NJ, 05, 0F, 24	7029722
ROMERO, VINNY	NJ, 05, 0F, 70	7095972
ROSS, ROBERT RAY	NJ, 05, 0F, 08	1328063
RUIZ, ROBERT	NJ, 05, 0F, 05	7082254
RUVALCABA, LUIS	NJ, 05, 0F, 51	7067650
SNOWDEN, JAHKARI	NJ, 05, 0F, 39	7084843
SOZA, RICO INEZ	NJ, 05, 0F, 20	7040570
VALLEJO, WILLIAM	NJ, 05, 0F, 45	7079378
VANG, LUE	NJ, 05, 0F, 26	7048445
VERDUGO, GREG DANIEL	NJ, 05, 0F, 06	7028851
VIDRIO, OLSWALDO BENITO	NJ, 05, 0F, 56	1208880
VILLANUEVA, ROMAN JULIAN	NJ, 05, 0F, 12	7032358
WYNN, BRANDON JOEL	NJ, 05, 0F, 48	1846114
YOUNG, JAYSON	NJ, 05, 0F, 71	7082497
TOTAL INMATES	**70**	

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1/31/2020

JAIL

NAME	FAC-FLR-CELL	JID
ABUSALEM, ALI IBRAHIM	NJ, 02, 0C, 16	0769992
AGUILERA, MARCUS ANTHONY	NJ, 02, 0C, 49	7023339
ALCOCER, ARTURO MCKINLEY	NJ, 02, 0C, 10	7075356
ALEJANDREZ, LEO	NJ, 02, 0C, 72	0930630
AMARAL, MARIO ANTHONY	NJ, 02, 0C, 21	7051582
ANGEL, ROBERTO	NJ, 02, 0C, 36	0294403
ARROYOS, ALFRED JOSE	NJ, 02, 0C, 71	7090240
BARRAZA, JUAN MANUEL	NJ, 02, 0C, 63	1226612
BRISENO, FELIPE	NJ, 02, 0C, 28	7024978
BROWN, JONATHAN DAVID	NJ, 02, 0C, 58	7073752
CARLIN, TONY DURAN	NJ, 02, 0C, 34	1812934
CASTRO, ABEL GREGORY	NJ, 02, 0C, 01	7088100
CERVANTES, VICTOR	NJ, 02, 0C, 12	7073566
CHAVEZ, BASILIO	NJ, 02, 0C, 26	7100450
CONTRERAS, ANDREW MICHAEL	NJ, 02, 0C, 65	7053846
CONTRERAS, FILIBERTO	NJ, 02, 0C, 45	0102085
COVINGTON, MATTHEW ERIN	NJ, 02, 0C, 55	1841267
CRUZ, DANIEL RUDY	NJ, 02, 0C, 61	7055964
DELEON, NICHOLAS WOLFGANG	NJ, 02, 0C, 64	7040300
DORSEY, GERALD WAYNE	NJ, 02, 0C, 59	1843443
ESCOBAR, DANNY	NJ, 02, 0C, 54	7066644
ESCOBAR, GILBERT	NJ, 02, 0C, 18	7070962
ESPINOSA, SHAUN MICHAEL	NJ, 02, 0C, 40	1814957
GALINDO, MIGUEL	NJ, 02, 0C, 25	1588442
GARCIA, JOSE ANTONIO	NJ, 02, 0C, 39	1795323
GARCIA, JUAN JEREMY	NJ, 02, 0C, 52	7093276
GARZA, ALFREDO	NJ, 02, 0C, 24	7047873
GOMEZ, MIKE FELICIANO	NJ, 02, 0C, 35	0067181
GONZALES, DANIEL	NJ, 02, 0C, 44	7005633
GONZALES, DEMETRIO	NJ, 02, 0C, 15	0990986
GOVEA, ANDRES RAFAEL	NJ, 02, 0C, 47	7054185
HANSSON, JOHN XAVIER	NJ, 02, 0C, 50	0235050
HER, TOUA	NJ, 02, 0C, 22	1725042
HERNANDEZ, MARCOS HERNANDEZ	NJ, 02, 0C, 38	7058347
HERNANDEZ, REYNALDO	NJ, 02, 0C, 33	7050691
JONES, FRELAND BRYAN	NJ, 02, 0C, 48	7011837
LAMATTINA, RAVEN	NJ, 02, 0C, 04	7098883
LEAVELL, ED EUGENE	NJ, 02, 0C, 57	7014627
LOFTIS, DION EDWARD	NJ, 02, 0C, 68	7093387
MADDOX, BRIAN WILLIAM	NJ, 02, 0C, 67	7057531
MARQUEZ, MARIANO RENE	NJ, 02, 0C, 53	7070005
MARSHALL, EUGENE DAJOHN	NJ, 02, 0C, 02	7018830

MARTINEZ, LEO JAMES	NJ, 02, 0C, 27	1814481
MONK, TIMOTHY CHARLES	NJ, 02, 0C, 42	1323375
MONTES DEOCA DIZA, MIGUEL ANG	NJ, 02, 0C, 56	7073555
MYERS, ANTHONY JARIED	NJ, 02, 0C, 32	7069585
OCAMPO, NICOLAS ANTHONY	NJ, 02, 0C, 37	0570609
OLSON, RICHARD EDWIN	NJ, 02, 0C, 69	7051088
OSORNIO, JESUS COLIMA	NJ, 02, 0C, 08	1486580
PERALTA, MICHAEL ANTHONY	NJ, 02, 0C, 23	7047357
PERALTA, PABLO JESUS	NJ, 02, 0C, 31	1824359
PEREZ, JULIO ESQUIVEL	NJ, 02, 0C, 17	7092024
PORTILLO, VICTOR MARIO	NJ, 02, 0C, 11	1190814
RAMOS, NESTOR DANNY	NJ, 02, 0C, 14	7006744
RANGEL, JUAN DANIEL	NJ, 02, 0C, 46	1658792
RODRIGUEZ, JORGE MUNOZ	NJ, 02, 0C, 13	7065759
RUIZ, ALEJANDRO	NJ, 02, 0C, 60	7044342
SANCHEZ, CARLOS AARON	NJ, 02, 0C, 09	1246846
SANCHEZ, FELIPE	NJ, 02, 0C, 03	7042712
SEDANO, PEDRO	NJ, 02, 0C, 66	0380630
TELLEZ, ROEL	NJ, 02, 0C, 05	1721471
THORNHILL, ERIC THOMAS	NJ, 02, 0C, 43	0328386
TORRES, SALVADOR REYES	NJ, 02, 0C, 07	7014589
TREVINO, LEO ARTHUR	NJ, 02, 0C, 29	1047502
VALERO, NICHOLAS	NJ, 02, 0C, 70	1349986
VARGAS, JOE LOPEZ	NJ, 02, 0C, 62	0595629
VENEGAS, FRANCISCO JAVIER	NJ, 02, 0C, 51	1817093
WINCHESTER, ROBERT PAUL	NJ, 02, 0C, 30	0174566
WORSTEIN, BRIAN LOUIS	NJ, 02, 0C, 19	1755848
YANG, DANIEL	NJ, 02, 0C, 20	1298374
ZEPPENFELDT, CHRISTIAN JAMES	NJ, 02, 0C, 41	7068602

TOTAL INMATES **71**

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CRIMINAL CASE STANDING ORDER RE: PROCEDURE FOR REVIEW OF DETENTION ORDERS IN LIGHT OF CORONAVIRUS PANDEMIC	Magistrate Judge Nat Cousins Effective March 16, 2020

I am issuing this criminal standing order on March 16, 2020, in response to the coronavirus pandemic. It applies to every open criminal case in which I have ordered a criminal defendant to be detained and that defendant is presently held in custody awaiting trial. Most detainees in this District are presently housed at Santa Rita Jail in Alameda County, California. Defendants detained by other judges are not covered by this standing order. A copy of this order will also be provided to the offices of the Federal Public Defender, the United States Attorney, the CJA attorney coordinator, U.S. Pretrial Services, and posted publicly on the Court's web page.

Under the Bail Reform Act, 18 U.S.C. § 3145(f)(2), a detention hearing may be reopened at any time before trial if the judicial officer finds that information exists that was not known to the movant at the time of the detention hearing and that has a material bearing on the issue whether there are conditions of release that will reasonably assure the appearance of such person as required and the safety of any other person and the community. Two of the detention or release factors (among others) to be considered by the judicial officer are (1) the person's "physical and mental condition" (3145(g)(3)(A)) and (2) the nature and seriousness of the danger to any person or the community that would be posed by the person's release (3145(g)(4)).

The Crime Victims' Rights Act, 18 U.S.C. § 3771, also provides crime victims the

statutory right to be reasonably protected from the accused, to reasonable notice of any public court proceeding involving the crime or release of the accused, the right to be reasonably heard and not excluded from public court proceedings, the right to be treated with fairness and respect, the right to confer with the attorney for the Government in the case, the right to proceedings free from unreasonable delay, and the right to be informed of the rights under the Act. The Court shall ensure the crime victim is afforded the rights described in the Act. 18 U.S.C. § 3771(b)(1).

This standing order sets forth the procedure for any request to reopen a detention hearing on the basis of the physical and mental condition of the accused. This public health crisis is serious and urgent. Counsel should not delay in evaluating whether any defendant should have his or her detention hearing reopened.

1. Counsel for the Government and accused must confer first in an effort to determine if they agree.

2. The Government must provide notice and an opportunity to confer and be reasonably heard to any crime victim.

3. Any stipulation or motion to reopen must be filed in the ECF system.

4. The motion should state whether the defendant waives personal presence at the hearing.

5. Copies of the motion to reopen must be provided to Pretrial Services and to Clerk's Office Manager Snooki Puli at Snooki_Puli@cand.uscourts.gov. This may be by email.

6. Unless otherwise ordered, no hearing will be held in person. Counsel, clients, and crime victims will be allowed to participate by telephone or video to the extent practicable.

IT IS SO ORDERED.

Date: March 16, 2020

Nathanael M. Cousins
United States Magistrate Judge

Kevin P. Rooney, #107554
Of Counsel, HAMMERSCHMIDT LAW CORPORATION
2445 Capitol Street, Suite 150
Fresno, CA 93721
Tel: (559) 233-5333
Fax: (559) 233-4333

Attorney for Defendant, ARMANDO ACOSTA TORO

IN THE UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. ARMANDO ACOSTA TORO, Defendant.	Case No.: 1:19 CR 256 NONE/SKO DECLARATION OF ATTORNEY KEVIN P. ROONEY IN SUPPORT OF MOTION TO REVOKE PRETRIAL DETENTION ORDER DUE TO DANGER STEMMING FROM COVID-19 COMPLICATIONS Date: March 27, 2020 Time: 8:30 a.m. Location: Hon. Dale A. Drozd

I, Kevin P. Rooney, declare:

1. I am a duly licensed attorney and I represent Armando Acosta Toro in the above captioned case.

2. Attached to the motion are declarations from several experts. I obtained those declarations from an Assistant Federal Defender involved in coordinating national efforts to address the ramifications of Covid-19 particularly issues arising from actual or potential custody .

3. I am informed and believe that the information contained within the declarations cited is true and correct.

4. Similarly, I relied on scientific research collected by the Federal Defender's Office in the Western District of Washington. I am informed and believe that information is accurate and properly cited.

5. I am informed and believe that all factual assertions made within the motion are true and correct.

I declare under penalty of perjury that the foregoing is true and correct, except as to those matters alleged under information and belief, and as to those matters, I believe them to be true, and that this declaration was signed in the County of Fresno, State of California.

Dated: March 23, 2020

/s Kevin Rooney
Kevin P. Rooney