DECLARATION OF DR. JOSEPH SHIN (MD, MSc.)

I, Joseph Shin, MD, MSc., make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. §1746 that the following is true and correct:

1. I am an Assistant Professor of Medicine at Weill Cornell Medicine, founding member of the Cornell Center for Health Equity, and past medical director for the Weill Cornell Center for Human Rights. I am a diplomate of the American Board of Internal Medicine and completed my medical training at NYU School of Medicine. Prior to my current role at Cornell, I was a Clinical Instructor at NYU School of Medicine and attending physician at Bellevue Hospital where I served at the NYU/Bellevue Program for Survivors of Torture, the Bellevue Adult Primary Care Clinic and also cared for hospitalized patients in the New York City Department of Corrections custody.

2. I have over fifteen (15) years of experience conducting as well as training other health practitioners to perform forensic medical evaluations for survivors of human rights abuses, asylum applicants and individuals held in immigration detention. I have conducted research related to trauma and health outcomes among asylum seekers and trafficking victims and medical neglect and barriers to care in immigration detention centers.

3. I also have extensive experience, expertise and knowledge of medical care in correctional settings including, but not limited to, immigration detention facilities.

The Expanding Coronavirus Pandemic

4. As of April 10, 2020, the date of this declaration, the COVID-19 pandemic has exponentially spread, with 1,619,495 confirmed cases and 97,200 deaths globally. [1] According to the Centers for Disease Control and Prevention (CDC) there have been 427,460 confirmed cases and 14,696 deaths nationally as of April 9, 2020 (the latest available data).[2] Every U.S. state and territory has been affected, and COVID-19 is rapidly spreading from urban centers to rural areas.

5. A study from the University of Texas at Austin estimated that as of April 3, 2020—a week ago—"72% of US counties with 94% of the national population have over a 50% chance of ongoing COVID-19 transmission."[3] The authors emphasized that "[a] single reported case suggests that community transmission is likely," and that even in

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[1]Johns Hopkins University Coronavirus Resource Center, https://coronavirus.jhu.edu/map.html (last updated April 9, 2020, 12:00 p.m. ET).

[2]Centers for Disease Control and Prevention, Coronavirus Disease19, Updated April 9, 2020; https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

[3] Emily Javan, et al., *Probability of current COVID-19 outbreaks in all US counties* (Apr. 3, 2020), https://cid.utexas.edu/sites/default/files/cid/files/covid-risk-maps_counties_4.3.2020.pdf?m=1585958755.

places that did not have confirmed COVID-19 cases as of April 3, 2020, the situation was not likely to last.[4]

6. Due to the highly infectious nature of COVID-19, infectious disease specialists and public health experts have strongly recommended minimizing interpersonal contact to mitigate transmission and minimize disease.[5] The US government like many around the world have taken unprecedented steps to follow expert recommendations by ordering the closure of all but essential businesses and putting into place strict social distancing policies such as "shelter in place," gatherings of no more than ten persons, and avoiding congregate environments such as schools and places of worship. It is likely that our entire map will be bright red within a week or two, given that COVID-19 spreads very quickly and often silently. The fate of outbreaks in counties across the US very much hinges on the speed of local interventions. Early and extensive social distancing can block community transmission, avert rises in hospitalizations that overwhelm local capacity, and save lives.[6]

7. The novel coronavirus is highly infectious and is thought to pass thought to pass from person to person through respiratory droplets released by coughing or sneezing as well as also through contact with infected individuals and interactions with contaminated surfaces. There is also increasing concern for the possibility of aerosolization and airborne transmission which might allow infectious viral particles to remain in the air and transmit infection to others without close contact. In addition to transmission by symptomatic individuals, there is a high level of transmission amongst asymptomatic carriers as well as pre-symptomatic infected individuals. Estimates suggest that 18-57% of infected people may not have symptoms at the time of testing.[7][8]

8. Furthermore, limited wide-spread testing in addition to narrow screening criteria have failed to effectively identify all individuals at risk of infection and transmission. Basic screening questions related to travel history, sick contacts and symptoms fail to acknowledge wide-spread community transmission and asymptomatic spread already taking hold in many communities across the country, as well as within institutional or congregant settings.

9. For individuals who do become symptomatic, many will experience relatively mild symptoms, but an estimated 10%-20% of individuals who are infected may need hospitalization with a significant portion of these requiring care in the intensive care unit. Severe complications including acute respiratory failure, sepsis, multiorgan

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[4] *Id.*

[5] https://www.cdc.gov/coronavirus/2019-ncov/index.html

[6] *Id.* (citations omitted).

[7] Mizumoto Kenji, Kagaya Katsushi, Zarebski Alexander, Chowell Gerardo. Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama, Japan, 2020. Euro Surveill. 2020;25(10)

[8] Kimball A, Hatfield KM, Arons M, et al. Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020. MMWR Morb Mortal Wkly Rep 2020;69:377–381.

failure, blood clots and death. The risks of these complications is much higher for COVID-19 patients with a case-fatality rate of approximately 3.9% which is nearly 40 times higher than that of seasonal influenza (~0.1%).[9]

10. It is often overlooked that half of hospitalizations are in patients less than 50 years old, and many young healthy people have died from COVID-19.[10]

11. There is no vaccine to prevent COVID-19. There are also no clearly effective treatments for this disease.

12. The only effective strategies to limit wide-spread impact of COVID-19 are public health strategies. These include containment efforts like early identification, contact tracing, isolation and quarantine measures, and intensive use of personal protective equipment. Unfortunately, due to limited testing capacity and public health resources combined with wide-spread community spread, mitigation efforts like social distancing and scrupulous hand and personal hygiene are critical to limit the spread of COVID-19.

Detention Facilities

13. The risks of wide-spread undetected transmission in detention facilities, as well as jails and prisons, is significantly higher than in the community. This represents a threat not just to people being detained or incarcerated but also to the hundreds and thousands of staff working in these facilities, their families and the broader community.

14. The risks of undetected and widespread transmission within detention facilities increases the risk to both the people who work in and are detained in these facilities. These risks in settings of detention and incarceration have been demonstrated in multiple past epidemics including influenza resulting in staff and inmate deaths. Furthermore, immigration detention facilities have also recently been sites of other preventable exposures and outbreaks including mumps and chicken pox.[11,12] These are all facilitated by relative overcrowding, poor hygiene measures, as well as medical neglect and limited access to medical care despite policies or best practices said to be established in these facilities.

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[9] Johns Hopkins University and Medicine – Coronavirus Resource Center – Mortality Analyses. https://coronavirus.jhu.edu/data/mortality (Accessed 4/12/2020)

[10] Wang D, Hu B, Hu C, et al. Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus–Infected Pneumonia in Wuhan, China. *JAMA*. 2020;323(11):1061–1069. doi:10.1001/jama.2020.1585

[11] https://www.cnn.com/2019/06/14/politics/mumps-chicken-pox-quarantine-ice/index.html

[12] Leung J, Elson D, Sanders K, et al. Notes from the Field: Mumps in Detention Facilities that House Detained Migrants — United States, September 2018–August 2019. MMWR Morb Mortal Wkly Rep 2019;68:749–750.

15. The lack of wide-spread testing, transparency and data in communities in the US and all across the world allowed undetected spread in the community as well as within facilities and institutions that fueled the current pandemic.

16. Congregate settings allow for the rapid spread of infectious disease, especially those passed by droplets through coughing and sneezing and also contact with contaminated surfaces. Shared dining halls, bathrooms, showers, common areas, sleeping quarters, and shared equipment such as telephones, all present opportunities for greater transmission. And while facilities might not be considered "overcrowded" by standard criteria, many of these shared facilities in the general population do not allow for the safe social distancing or regular hand hygiene practices recommended by public health experts.

17. The lack of wide-spread testing, transparency and data in communities in the US and all across the world allowed undetected spread in the community as well as within facilities and institutions that fueled the current pandemic.

18. Detention centers, jails and prisons, despite what might be considered "safe capacity", are largely incapable of establishing the recommended levels of social distancing that is essential to mitigate the spread of this disease.

19. In preparation of this Declaration, I have been provided with the Declaration of Liana J. Castano, dated April 8, 2020 ("Castano Declaration"). The following are my responses to the Castano Declaration. The language used in the declaration demonstrates knowledge of the appropriate precautions, but presents a plan claiming to implement what are clearly inadequate measures - that violate the CDC guidance - and knowingly expose anyone interacting with the faculty to an even more elevated deadly risk of contracting COVID.

Krome

A. Screening Measures at Krome

20. The Castano Declaration describes screening measures that are not effective in preventing the spread of COVID-19. *See* Castano Declaration, ¶¶7-9, 16-17.

21. The Castano Declaration discusses screening measures that have been implemented at Krome. However, the screen measures are not sufficient. New data has demonstrated that asymptomatic persons infected with the novel coronavirus SARS-CoV-2 (the virus that causes COVID-19) can be contagious and spread infection.[13] This new data

[13] See Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html#studies (Apr. 3, 2020).

prompted the CDC to recommend as of April 3, 2020 that everyone wear masks in public to help mitigate spread of disease.[14]

22. It presently believed that COVID-19's incubation period, the time between infection and appearance of symptoms is 2-14 days. However, a substantial percentage of infected persons may never show symptoms (i.e. asymptomatic) or be mildly infected. The evidence that is available points to a high likelihood of both scenarios.

23. At the writing of this declaration there is not conclusive evidence whether the infection can be spread during the incubation period or whether virus can be shed in mildly symptomatic or asymptomatic person (i.e. be contagious). However, the evidence that is available points to a high likelihood of both scenarios. A recent review of the literature related to COVID-19 appears in the highly respected scientific journal, Nature.[15] Based on various epidemiological models, "covert cases" (i.e. asymptomatic to mildly symptomatic persons) may represent up to 60% of all COVID-19 infections.[16] People with mild or no symptoms would typically not seek medical care (and not be tested) and would therefore not be detected during screening protocols. Epidemiologists believe that these covert cases that have contributed to the spread of COVID-19 in a global population where no one is immune.[17]

24. The article in Nature reviews three studies that support the likelihood that asymptomatic or mildly symptomatic individuals can spread the infection. These studies took place in China, Japan and one study included passengers from the Diamond Princess. These studies found that in COVID infected persons, 59%, 31% and 18%; respectively, were asymptomatic or mildly symptomatic.[18]

25. Moreover, new studies of the ability of infected persons to shed virus also point strongly to the ability to spread disease prior to symptoms developing. These studies showed high viral load in the pharynx at the onset of symptoms and even in an asymptomatic infected person. The article quotes Dr. Michael Osterholm, director of the University of Minnesota's Center for Infectious Diseases Research and Policy in Minneapolis who states that while more "The data confirm what many scientists have suspected: that some infected people 'can be highly contagious when they have mild or no symptoms' although the scale of the problem is still unclear."[19]

26. Evidence that demonstrated that ability of asymptomatic infected persons to spread the virus makes it impossible for screening protocols to identify all those who infected and contagious. A recently published study by the CDC has shown strong evidence suggesting the spread of infection by asymptomatic COVID-19 infection.

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[14] Id. ("In light of this new evidence, CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain (e.g., grocery stores and pharmacies) especially in areas of significant community-based transmission.") (emphasis in original).
[15] Nature.com; doi: 10.1038/d41586-020-00822-x).
[16] ibid.
[17] ibid.
[18] ibid.
[19] ibid.

The authors conclude that the findings have implication in "containment measures" and that "to control the pandemic it might not be enough for only persons with symptoms to limit their contact with others because persons without symptoms might transmit infection." The authors specifically state, "these findings underscore the importance of social distancing in the public health response to the COVID-19 pandemic, including the avoidance of congregate settings."[20]

27. The lack of wide-spread testing, transparency and data in communities in the US and all across the world allowed undetected spread in the community as well as within facilities and institutions that fueled the current pandemic.

28. The screening measures discussed in the Castano Declaration are not sufficient and will continue to result in the spread of COVID-19 at Krome and in the community.

B. Co-horting at Krome

29. The Castano Declaration discusses the use of cohorting at Krome. *See* Castano Declaration, ¶10, 12.c..

30. Cohorting is "the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group." The CDC's *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (the "Interim Guidance")[21] at 3. It is not the same as quarantine or medical isolation, and is to be used only as a last resort in those "correctional facilities and detention centers do not have enough individual cells" for quarantine or medical isolation. The practice of cohorting is dangerous in that it risks "transmit[ting] COVID-19 from those who are infected to those who are uninfected." *Id.* at 19.

31. The Castano Declaration that discusses the use of cohorting directly contradicts CDC guidance in several ways including, most critically, that ICE officials describe cohorting as the planned response to a known COVID-19 exposure, not a practice of last resort. Notably, ICE has no plans to place suspected COVID-19 cases in individual medical isolation in which "[e]ach isolated individual should be assigned their own housing space and bathroom" as recommended by CDC. *See* Interim Guidance at 15.

32. The Castano Declaration states that "238 detainees" are currently cohorted. there is no indication that a cohorted group will be permitted to practice social distancing as recommended by CDC (*Id.* at 16), or that a cohorted group will be provided with masks to prevent transmission of COVID-19 (*Id.* at 20).

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[20] Wycliffe E. Wei, et al., *Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020*, https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e1.htm (Apr. 1, 2020).

[21] Centers for Disease Control, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf.

33. Finally, cohorting in a selective manner without the implementation of wide-spread testing puts everyone at very high risk of contracting and spreading COVID-19.

C. Social Distancing

34. The Castano Declaration discusses various social distancing measures. The measures detailed in the Castano Declaration are not sufficient to address the COVID-19 pandemic.

35. The CDC recommends the following ways to protect oneself: social distancing (keeping at least 6 feet between persons), frequent hand washing with soap and water for minimum of 20 seconds after being in public places or after sneezing or coughing, or blowing ones nose; use of hand sanitizers with at least 60% alcohol and avoid touching unwashed hands to one nose, eyes and mouth. Furthermore, the CDC recommends cleaning all surfaces with EPA-registered disinfectants that typically contain bleach or alcohol.[22]

36. Individual as well as published accounts by journalists question the effectiveness of purported containment and mitigation efforts within jails, prisons and detention centers. Shared facilities, "shoulder-to-shoulder" seating during meals, standard density and distances between beds and bunks in sleeping quarters as well as showers and toilets in congregate units all suggest that many routine practices have not changed in light of the current pandemic.

37. Detention centers, jails and prisons, despite what might be considered "safe capacity", are largely incapable of establishing the recommended levels of social distancing that is essential to mitigate the spread of this disease.

38. Congregate settings allow for the rapid spread of infectious disease, especially those passed by droplets through coughing and sneezing and also contact with contaminated surfaces. Shared dining halls, bathrooms, showers, common areas, sleeping quarters, and shared equipment such as telephones, all present opportunities for greater transmission. And while facilities might not be considered "overcrowded" by standard criteria, many of these shared facilities in the general population do not allow for the safe social distancing or regular hand hygiene practices recommended by public health experts.

39. In conclusion, the CDC guidelines require that "cohorting" should only be used as a last resort. There is no way for immigration detention facilities to comply with CDC guidelines on social distancing and quarantining unless Respondents release detained men and women on a large scale. When release from a detained setting is an option and there is lack of testing ability and an inability to employ social distancing, it is my professional opinion that failure to release during the COVID-19 pandemic is a

[22] https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html

violation of the CDC guidelines and will result in continued and wide-spread infection.

40. The analysis that I provide above regarding screening, "cohorting" and social distancing is not theoretical. In fact, there are a growing number of facilities throughout the country where the rate of infection is growing exponentially amongst both people detained as well as staff. In these settings, hundreds, and potentially thousands of people will become infected, and many will die. This is a direct result of a failure to implement the recommended measures at an early enough to stage to prevent illness and save lives. Already, some ICE facilities the numbers of detected COVID-19 infections are growing at an exponential rate. By the time facilities recognize this kind of exponential growth in detected cases, it will already be too late. Therefore, individuals should be released from detention.

41. It should also be understood that all individuals are suspectable to infection and serious life-threatening complications that can result in death. As is stated above, I am a treating physician at Weill Cornell and since the beginning of the COVID-19 pandemic I have been actively involved in our hospital's response and in directly treating patients. I have personally treated patients-many of these individuals are young and did not have any pre-existing medical conditions. Many of the patients are currently in our Intensive Care Unit (ICU) in respiratory failure and on life support.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, based on my personal knowledge. Executed in New York, NY on April 13, 2020.

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