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DECLARATION OF DR. JULIE DEAUN GRAVES

I, Dr. Julie DeAun Graves, declare as follows:

1. My name is Julie DeAun Graves. I am a physician licensed to practice medicine in the states of Florida, Maryland, New Jersey, South Carolina, Texas, Virginia, Wisconsin, and in the District of Columbia. I am currently working in family medicine and public health private practice as the Associate Director of Clinical Services at Nurx. I have been certified by the American Board of Family Medicine since 1989.

2. I am a public health physician, previously serving as Regional Medical Director for the Texas Department of State Health Services for the Houston region, as Medical Services Coordinator for the Texas Department of Aging and Disability Services, and as a medical consultant to the Texas Medical Board. I managed the H1N1 influenza outbreak for the Texas State Supported Living Centers and oversaw public health efforts for the Houston region (population seven million) for Ebola virus, Zika virus, West Nile virus, highly pathogenic avian influenza, tuberculosis outbreaks, and natural disasters.

3. I obtained my medical degree and completed a surgical internship then family medicine residency at the University of Texas Southwestern Medical School in Dallas, Texas, then completed a fellowship in faculty development at the McLennan County Medical Education and Research Foundation in Waco, Texas. I earned a Master's degree in Public Health and a Doctor of Philosophy in Management, Policy, and Statistics at the University of Texas School of Public Health. I have practiced family medicine and public health since 1989, and in 2018-2019 I was Associate Professor and Vice-Chair for Education at

Georgetown University School of Medicine. At Nurx I care for patients seeking contraception, HIV (human immunodeficiency virus) prevention, sexually transmitted infection diagnosis and treatment, cervical cancer screening, and coronavirus (SARS-CoV-2, the virus that causes COVID-19) testing and treatment. I am a former member of the Public Health Committee of the Texas Medical Association and a former member of the Executive Board and current Governing Councilor of the American Public Health Association.

COVID-19

4. COVID-19 is an illness caused by the SARS-CoV-2 virus, which is a novel coronavirus that was first detected in humans during the outbreak (now a pandemic) we are experiencing now. The Centers for Disease Control and Prevention reports that as of March 31, 2020 at 1:30pm there were 175,067 cases reported in the United States, with cases reported in every state, and 3,415 reported deaths so far. See www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6. On March 18, 2020, there were 7,038 cases reported and 150 deaths.

5. The United States is in the early stages of the pandemic, and because there has been insufficient testing for cases, the reported cases numbers are lower than actual cases. There is a high probability that there are many more infected individuals in the population. The spread of the virus is faster and more dangerous when people are in close quarters. People with health conditions such as diabetes, asthma, emphysema, heart disease, kidney disease, pregnancy, diabetes, cancer, HIV, and autoimmune diseases such as lupus and rheumatoid arthritis are at higher risk for severe illness, complications, and death

from COVID-19. People over age 60 have higher death rates, but severe cases of illness and deaths are reported in people of all ages, including children. The ratio of cases of COVID-19 to deaths from this illness is much higher than for other contagious diseases such as influenza. The SARS-CoV-2 virus damages the lung tissue, which means that even those who recover need prolonged medical care and rehabilitation. They are likely to have permanent disability from loss of lung capacity. The heart itself can be infected, and kidneys and the nervous system can also be impacted and damaged permanently.

6. There is no vaccine and no treatment for COVID-19. We only have prevention as a tool to stop the pandemic. If people remain in congregate settings, most of them plus the staff who work with them will become infected, and many will die or have permanent disability. COVID-19 is transmitted from person to person by breathing in expired air that contains the droplets an infected person has coughed or the virus they have shed, or by touching a surface with the virus on it, unless there is full personal protective equipment: mask, gloves, gown, plus thorough hand washing before putting on the equipment and after removing it. The only way to avoid transmission is for people to distance themselves at least six feet from others (commonly referred to as "social distancing" or "physical distancing"). People should not be in large buildings full of many people, and people must practice frequent and thorough hand washing with adequate soap and water. If we do not implement these two steps – physical distancing and hand washing – the pandemic will only continue to spread and the number of deaths will continue to increase.

7. There is a national shortage of COVID-19 tests. Medical providers cannot test everyone who they believe should be tested, and so are

presuming that people with a certain set of symptoms are positive. This is an appropriate and common situation with new infectious diseases and is a widely recognized strategy in public health disease control. Individuals and communities should not rely solely on the criteria of a positive COVID-19 test to implement precautions or quarantine symptomatic persons. A public health response requiring widespread preventive measure of physical distancing and appropriate hand washing is our only tool to slow the spread of the virus.

8. While children may make up a minority of COVID-19 patients, children have died from COVID-19 and have also experienced serious medical complications that required ventilators and extended hospitalization. Additionally, children with pre-existing medical conditions such as asthma and diabetes are at heighted risk for serious complications.

9. There is no question that requiring children to remain detained in congregate care facilities is more dangerous than the travel required to release children to their homes. While there is level of risk in traveling at this time, the risk of exposure in congregate care environments is much higher. All of the risks of exposure during travel – such as persons coming within six feet and transmitting the virus through respiratory droplets – also apply to congregate care environments, because multiple staff members are constantly entering and exiting the facility and there is potential for them to expose children to the virus. These children are at risk every single time a staff member or visitor walks into the facility – because any one of them could be an asymptomatic carrier of COVID-19. Even if juvenile and criminal justice facilities faithfully adhere to screening protocols to minimize the risk of transmission, there is still the risk that a staff member is an

asymptomatic carrier. Children will be significantly safer in a home environment, where they can truly avoid public spaces and practice appropriate social distancing.

10. Many facilities are quarantining youth who exhibit coughing, fever, or difficulty breathing. This response is too late – if a child is not quarantined when there is an initial exposure, then there is much higher likelihood that the virus spreads around the facility, especially when everyone is in such close contact and social distancing is not possible.

CDC COVID-19 Guidance for Correctional and Detention Facilities

11. I have reviewed the CDC "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" (CDC Detention Facility Guidance) issued March 23, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html. The CDC Detention Facility Guidance highlights many ways in which people in detention facilities and congregate environments are at a higher risk of contracting COVID-19.

12. The CDC Detention Facility Guidance acknowledges that "(i)ncarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced." Further, it states that "(t)here are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members."

13. The CDC Detention Facility Guidance instructs facilities to "implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally six feet between all individuals, regardless of the presence of symptoms," but acknowledges that "not all strategies will be feasible in all facilities." Social distancing does not work when it is only followed part of the time. The CDC's "Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)" issued on March 7, 2020 states that "(d)ata are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to result in transmission; however, clinical symptoms of the patient and type of interaction (e.g., did the patient cough directly into the face of the HCP) remain important" and "(e)xamples of brief interactions include: briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation at a triage desk with a patient who was not wearing a facemask." Repeated interactions, even brief, that occur throughout the day in these facilities, are each an independent opportunity for transmission of infection. Because it is not known whether people who have recovered from infection develop immunity to subsequent infections with COVID-19, and because transmission may occur when the infected person has no symptoms, each interaction between a staff member and a detainee and each interaction between two individual detainees or two individual staff members is an independent opportunity with the same risk of infection. The risks are additive with each interaction.

14. The CDC Detention Facility Guidance states that "The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent hand washing) may be limited and is determined by the supplies provided in the facility and by security considerations." Facilities are instructed to provide no-cost access to liquid soap (or bar soap), running water, and hand drying supplies.

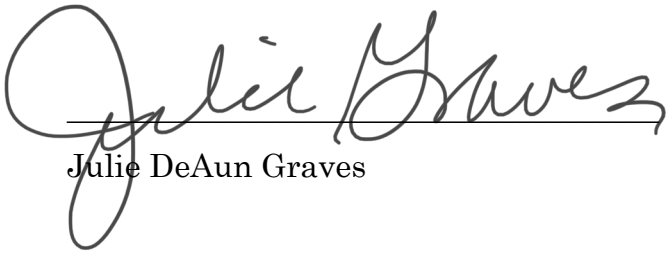
15. Detention facilities are instructed to "(o)ffer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza seasons." Preventing influenza cases in these facilities can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.

16. Even if all of the recommendations made in the CDC Detention Facility Guidance are followed, the conditions of detention are such that children in detention and correctional settings would still be at high risk of contracting COVID-19. Because this virus is transmitted through droplets, through the air, and on surfaces, and because people who do not have symptoms but are infected transmit the virus to others, even one infected person in a facility, either a detainee or a staff member, can infect the majority of people in the facility. This is worsened by the crowded conditions in the facilities.

17. If we are to contain the spread of the COVID-19 virus, we must relocate as many people as possible out of congregate settings. If we prevent people from practicing adequate physical distancing from others and the other steps outlined above, institutional centers will become clusters in which high percentages of persons are infected with COVID-19. Such clusters not only endanger those who are immediately

infected, but the health of those residing in the communities in which congregate facilities are located.

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 31, 2020 in North Bay Village, Florida.



Julie DeAun Graves