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

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

I. Background

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and professor of family medicine at the Georgetown University School of Medicine, where I am the director of the department's Global Health Initiatives, Health Policy fellowship, and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master's degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).
2. I am the faculty leader for Georgetown University School of Medicine's Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons, and detention centers. In addition, I am the director of Georgetown University's Asylum program, which focuses on the care and medical-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations, and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.¹

¹ See, e.g., Ranit Mishori, "Risk Behind Bars: Coronavirus and Immigration Detention," *The Hill* (Mar. 17, 2020), <https://thehill.com/opinion/immigration/487986-risk-behind-bars-coronavirus-and-immigration-detention>; Amanda Holpuch, "Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say," *The Guardian* (Mar. 11, 2020), <https://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers>; Abigail Hauslohner, et al., "Coronavirus Could Pose Serious Concern in ICE Jails, Immigration Courts," *The Washington Post* (Mar. 12, 2020), https://www.washingtonpost.com/immigration/coronavirus-immigration-jails/2020/03/12/44b5e56a-646a-11ea-845d-e35b0234b136_story.html; Silvia Foster-Frau, "Coronavirus Cases in Migrant Detention Facilities Called 'Inevitable,'" *Express News* (Mar. 15, 2020), <https://www.expressnews.com/news/us-world/border-mexico/article/Whether-in-detention-or-in-Mexico-U-S-15129447.php>.



3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants, and refugees. I routinely come into contact with victims of abuse, trauma, and poverty, where I regularly assess their medical as well as psychosocial needs in the context of their social determinants of health (such as housing and incarceration).
4. For four years, I was an elected member of the American Academy of Family Physicians' Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a one of the lead authors of the Academy's comprehensive position paper on Incarceration and Health.
5. My CV is attached as Exhibit A.

II. COVID-19

6. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. COVID-19 has now reached pandemic status. As of March 19, 2020, according to the World Health Organization (WHO), more than 194,000 people have been diagnosed with COVID-19 around the world and 7,864 have died.² In the United States, about 5,880 people have been diagnosed and 107 people have died as of the same date.³ The numbers of infection and death in the United States are likely underestimated due to the lack of test kits available.
7. The transmission of SARS-CoV-2 is expected to grow exponentially. Nationally, projections by the Centers for Disease Control and Prevention (CDC) indicate that more than 200 million people in the United States could be infected with SARS-CoV-2 over the course of the pandemic without effective public health intervention, with as many as 1.5 million deaths in certain projections.
8. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but also survives on surfaces for some period of time. It is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where SARS-CoV-2 originated, the average infected person passed the virus on to two the three other people; transmission occurred at a distance of three to six. The "contagiousness" of this novel coronavirus – its Ro (the number of people who can get infected from a single infected person) – is twice that of the flu. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of

² See Novel Coronavirus (COVID-19) Situation, World Health Organization, <https://experience.arcgis.com/experience/685d0ace521648f8a5beeee1b9125cd>, accessed Mar. 18, 2020 (at noon EDT).

³ See Mitch Smith, et al., "U.S. Coronavirus Map: Cases Now Reported in All 50 States," *The New York Times*, <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1>, accessed Mar. 18, 2020 (at noon EDT).



- infection because our immune systems have never been exposed to or developed protective responses against this virus.
9. COVID-19 is a serious disease, which can lead to respiratory failure, kidney failure, and death. Older patients and patients with chronic underlying conditions are at a particularly high risk for severe cases and complications.⁴ The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about 10 times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems. According to preliminary data from China, serious illness, sometimes resulting in death, occurs in up to 16 percent of cases, with a higher rate among those older and high-risk individuals.⁵
 10. The CDC previously identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including: blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.
 11. Those in high-risk categories who do not die may have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are likely to soon be in very short supply, and an entire team of care providers, including 1:1 or 1:2 nurse-to-patient ratios, respiratory therapists, and intensive care physicians. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.
 12. Complications from COVID-19, including severe damage to lung, heart, liver, or other organs, can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.
 13. There is no vaccine to prevent COVID-19. There is no known cure or antiviral treatment for COVID-19 at this time.
 14. COVID-19 prevention strategies include containment and mitigation. Containment requires identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment.

⁴ Fei Zhou, et al., “Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China,” *The Lancet* (published online Mar. 11, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext).

⁵ *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention, accessed Mar. 14, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/summary.html>.



Unfortunately, due to the lack of testing availability, most public health experts agree that it is too late to effectively implement a containment strategy in the United States at large.

15. As the infectious disease spreads in a community, public health demands mitigation strategies, which include scrupulous hand hygiene and social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of COVID-19. Schools, courts, collegiate and professional sports, theater, and other congregate settings have been closed as part of this risk mitigation strategy.

III. Detention Centers, Jails, and Prisons

16. The risk posed by infectious diseases in immigration detention facilities, including jails and prisons, is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
17. Globally, outbreaks of contagious diseases are all too common in confined detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. ICE has temporarily suspended social visitation in all detention facilities.⁶ However, staff arrive and leave on a shift basis; there is no ability to adequately screen staff for new, asymptomatic infection. Contractors and vendors also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities.
18. Jails, prisons, and detention centers often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits.
19. During an infectious disease outbreak, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Jails and prisons are often under-resourced and ill-equipped to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak. This is especially true when, as now, facemasks are already in short supply.
20. When jailed or imprisoned, people have much less opportunity to protect themselves by social distancing than they would in the community. 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 live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater.

⁶ *ICE Guidance on Covid-19*, U.S. Immigration and Customs Enforcement, accessed Mar. 18, 2020 (at 1:00 p.m. EDT), <https://www.ice.gov/covid19>.



Toilets, sinks, and showers are shared, without disinfection between use. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world – including their family and lawyers. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

21. Additionally, jails and prisons are often unable to adequately provide the mitigation recommendations described above. 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 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.
22. People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.⁷ This is because people in jails and prisons, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and suppressed immune systems from HIV or other conditions, than people in the community.
23. Jails and prisons are often poorly equipped to 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 negative pressure rooms. Most jails and prisons have few negative pressure rooms, if any, and these may already be in use by people with other conditions (including tuberculosis or influenza). ICE has admitted that not all of the detention centers it oversees have even one.⁸ In the course of an infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.
24. Even assuming adequate space, solitary confinement is not an effective disease containment strategy. Isolation of people who are ill using solitary confinement is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms, air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other

⁷ “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](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext).

⁸ Brittny Mejia, “ICE Says No Confirmed Coronavirus Among Detainees After 4 Test Negative,” *Los Angeles Times*, accessed Mar. 18, 2020, <https://www.latimes.com/california/story/2020-03-10/ice-says-no-detainees-have-coronavirus-four-being-tested>



people in prison and staff. This makes both containing the illness and caring for those who have become infected much more difficult.

25. Infectious disease outbreaks, such as COVID-19, may exacerbate existing mental health conditions and contribute to the development of new mental health conditions.⁹ Mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. Moreover, failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by an infectious disease outbreak such as COVID-19, may result in poor health outcomes and even death. The scientific evidence points to a bi-directional relationship between mental health conditions and infectious diseases. Not only are individuals with mental health conditions more at risk for communicable diseases, they are also harder to treat, once infected, due to the nature of their underlying mental health disorder. For individuals in these facilities, especially those with chronic mental health conditions, the experience of an epidemic and the lack of care while confined to small, crowded quarters can itself be traumatizing, compounding the trauma of incarceration.
26. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon enough many are sick – including high-risk groups such as those with chronic conditions – quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may be transferred.
27. 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 two facilities in Maine, resulting in two inmate deaths.¹⁰ Subsequent CDC investigations of 995 inmates and 235 staff members across the two facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.¹¹ H1N1 is far less contagious than COVID-19. These scenarios occurred in the “best case” of influenza, a viral infection for

⁹ Brian Honermann, *An “Epidemic Within an Outbreak:” The Mental Health Consequences of Infectious Disease Epidemics*, O’Neill Institute for National and Global Health Law (Feb. 26, 2015), accessed Mar. 19, 2020, <https://oneill.law.georgetown.edu/epidemic-within-outbreak-mental-health-consequences-infectious-disease-epidemics/>; Müller N, *Infectious Diseases and Mental Health*, Comorbidity of Mental and Physical Disorders; Shultz JM, *Mental Health Consequences of Infectious Disease Outbreaks*, accessed Mar. 19, 2020, <https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/flrtc/documents/Slides-MH-CONSEQUENCES-OF-ID-OUTBREAKSV2.pdf>.

¹⁰ *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention, Apr. 6, 2020, <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

¹¹ 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/>.



- which there was an effective and available vaccine and antiviral medications – unlike COVID-19, for which there is currently neither.
28. In recent years in immigration detention facilities, overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of other infectious diseases as well, including mumps and chickenpox.
 29. Additionally, as health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions.
 30. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of SARS-CoV-2. Not surprisingly, Chinese prison officials report that more than 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined.
 31. In my professional opinion, it is inevitable that SARS-CoV-2, the virus that causes COVID-19, will infect a prison, jail, and/or other immigration detention center in the United States. This is consistent with the prediction of other experts that all prisons and jails should anticipate that the coronavirus will enter their facility.

IV. New York City Area Jails

32. In the New York City area, hit hard by COVID-19, 1,871 people had tested positive as of March 18, 2020.¹² That number is also growing exponentially. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the Bergen, Essex, Hudson, and Orange County jails used as ICE detention facilities. In fact, an inmate at New York City’s Rikers Island jail, in addition to one of its correctional officers, has already tested positive for COVID-19.¹³
33. 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 press release entitled “Immigrants in NJ Detention Center Organize Hunger Strike; NYIFUP Condemns Egregious Conditions in Local ICE Jails Amid COVID-19 Pandemic”; (2) The Government’s Response to the Petitioner’s Letter of March 13, 2020, Seeking Immediate Interim Relief, and in Further Opposition to the Petition for a Writ of Habeas Corpus in *Jovel v. Decker, et al.* dated March 17, 2020; (3) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (4) the report “Ailing Justice: New Jersey,

¹² “As Testing Expands, Confirmed Cases of Coronavirus in N.Y.C. Nears 2,000,” *The New York Times*, accessed Mar. 18, 2020 (at 6:00 p.m. EDT), <https://www.nytimes.com/2020/03/18/nyregion/coronavirus-new-york-update.html#link-455277b4>.

¹³ *Id.*, accessed Mar. 18, 2020 (at 6:00 p.m. EDT)



Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention,” released by Human Rights First in 2018.

34. Based on my review of these materials, my experience working with detainees in local jails and immigration centers, my experience working with the formerly incarcerated, my training in public health, and my review of the relevant literature, it is my professional judgment that 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.
35. The government’s response that I read states that the Hudson County Correctional Center, which was at issue in that case, has taken the following steps to attempt to mitigate the transmission and spread of COVID-19: “all inmate visits have been suspended for 31 days; contact visits (for attorneys) have been suspended; all visiting areas are cleaned and sanitized after each visit; video visitation and conferencing is available; hand sanitizers are available to all individuals coming to the facility; etc. Further, the facility will not accept any ICE detainees that have traveled to China, Italy, or Iran within the last 31 days; any border arrests; or any street arrests that have not been tested for COVID-19 and medically cleared.” None of these steps are adequate to mitigate the transmission of the virus when there is already documented community-based transmission, and spread of coronavirus from staff, vendors, or contractors. They are also wholly inadequate to mitigate the spread of coronavirus once it has entered the facility.
36. The lack of adequate soap and hand sanitizer available to detainees in at least the Hudson County and Orange County facilities, as detailed in the NYIFUP press release, will contribute to widespread transmission of coronavirus should it enter either of these facilities. A lack of cleaning supplies as documented at Hudson County will do the same. Notably, the government’s response that I read only mentions that “hand sanitizers are available to all individuals *coming* to the facility,” (emphasis added), which is consistent with the complaints from detainees that they are not receiving such basic and essential resources.
37. The use of solitary confinement for social distancing in the Hudson County and Orange County facilities is inadequate to protect those inside the facilities from the transmission of coronavirus for the reasons detailed above. Further, it is harmful in and of itself to healthy inmates, let alone to those who are sick with a potentially severe illness.¹⁴
38. Additionally, there was a mumps outbreak at the Bergen County facility last year that was not adequately managed despite the use of “quarantine” and the fact that the

¹⁴ Keramet Reiter, Joseph Ventura, David Lovell, et al. “Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017-2018,” 110 *Am J. Public Health* (Jan. 1 2020), <https://doi.org/10.2105/AJPH.2019.305375>.



population in the United States has a high level of immunity to mumps due to vaccination.¹⁵

39. 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.
40. Failure to provide individuals adequate medical care for underlying chronic health conditions results in increased risk of infection-related morbidity and mortality if they do become infected.
41. 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 SARS-CoV-2 transmission.
42. 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 disease epidemic.
43. 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.

V. Conclusion and Recommendations

44. 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 SARS-CoV-2 as compared to the population in the community and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac, and kidney failure) and even death.
45. Given that the only viable public health strategy available in the United States currently is risk mitigation, reducing the size of the population in jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless, given the public health realities we now face in the United States.

¹⁵ Stephen Rex Brown, "ICE Jail in Bergen County Quarantined After Mumps Outbreak Among Immigrants Facing Deportation," *New York Daily News* (Jun. 11, 2019), <https://www.nydailynews.com/new-york/ny-mumps-ice-jail-20190611-fc6rgxibc5g2xjaehbz7yssvfi-story.html>; Doug Criss, "6 Inmates at a New Jersey Jail Came Down With the Mumps. The Entire Facility is Now Quarantined," *CNN* (Jun. 13, 2019), <https://www.cnn.com/2019/06/12/us/mumps-jersey-bergen-county-jail-trnd/index.html>.



46. Even with the best-laid plans to address the spread of SARS-CoV-2 in detention facilities, the release of individuals at a high risk of infection, complications, and poor outcomes is a key part of a risk mitigation strategy. In my professional opinion, the only viable public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of an effective vaccine for prevention or effective treatment for the disease at this stage. My professional opinion is consistent with the view of the medical profession as a whole that there are no conditions of confinement in carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.
47. Immediate release is crucial for individuals with chronic illnesses or other preexisting conditions (e.g., blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy). Those who are over the age of 60 are particularly vulnerable to severe complications of the disease, including death.
48. Releasing people from incarceration is the best and safest way to prevent the spread of disease and reduce the threat to the most vulnerable incarcerated people. It is my professional opinion that this step is both necessary and urgent. The window of opportunity is rapidly narrowing for mitigation of COVID-19 in these facilities. It is a matter of days, not weeks. Once a case of SARS-CoV-2 is identified in a facility, it will likely be too late to prevent a widespread outbreak.
49. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.
50. Release of the most vulnerable people also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

VI. Expert Disclosures

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

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

Executed this 19 day of March, 2020 in [Washington, D.C.].

Ranit Mishori, M.D, MHS, FAAFP