EXHIBIT D

No. _____

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JENNY LISETTE FLORES, et al.
Plaintiffs-Appellees,

v.

WILLIAM P. BARR,
Attorney General of the United States, et al.
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

DECLARATION OF JALLYN SUALOG,
DEPUTY DIRECTOR, OFFICE OF REFUGEE RESETTLEMENT

I, Jallyn Sualog, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that my testimony below is true and correct:

1. I am the Deputy Director of the Office of Refugee Resettlement ("ORR"), an Office within the Administration for Children and Families ("ACF"), U.S. Department of Health and Human Services ("HHS").

2. I have held the position of Deputy Director since June 2018. I was previously the Director of Children's Services from September 2013 through June 2018. I have worked at ORR since February 2007. I have a Master's of Arts in Clinical Psychology. Before joining ORR, I worked as a mental health professional

and managed the child welfare and social services programs for Hawaii's largest non-profit organization.

3. As the Deputy Director of ORR, I have responsibility for the oversight of the Unaccompanied Alien Children ("UAC") program, including all aspects of operations, planning and logistics, medical services, and monitoring. My job duties include the formulation and implementation of ORR's response to coronavirus disease 2019 (COVID-19) across its network of grantee care-provider facilities. In the course of performing my duties, I have gained personal knowledge of the factors that impact ORR operations, and the challenges associated with implementing ORR's COVID-19 infection control protocols.

4. My testimony in this declaration is based upon this personal knowledge, and information obtained from records and systems maintained by ORR in the regular course of performing my job duties.

5. I am testifying in this declaration to the best of my knowledge, and understand that this declaration is for use in the Government's appeal of the district court's September 4, 2020 order in *Flores v. Barr*, No. 2:85-cv-04544-DMG-AGR (C.D. Cal.), Dkt. No. 976 ("September 4 Order").

The district court's order will significantly disrupt ORR operations and endanger UAC and ORR personnel

6. I have been asked by ORR leadership to assess the potential impact that material changes in the current ORR operating environment would have on ORR program operations, including the impact of the September 4 Order.

7. It is my understanding that the September 4 Order directs the Government to cease temporarily housing alien minors in hotels pending their expulsion pursuant to the CDC Order prohibiting the introduction of certain "covered aliens" into the United States.

8. I understand that in the September 4 Order, the district court determined that minors held pursuant to the CDC Order are also members of the *Flores* settlement class, and therefore must be transferred "as expeditiously as possible" to a licensed ORR grantee care provider facility if "a bed in a licensed facility is immediately available." Dkt. No. 976, 17, para.1. I also understand that the September 4 Order directs that, once in ORR care, any minors subject to the CDC Order must be treated identically to the population of UAC that it is ORR's statutory mission to care for. *See id.*

9. It is my understanding the district court stayed the September 4 Order until midnight on September 8, after which, the U.S. Department of Homeland Security (DHS) must cease placing minors in hotels by September 15. *Id.* at 17, para.2. Absent an emergency stay, I anticipate that on or about September 15, ORR

will begin receiving referrals from DHS of alien minors who would otherwise have been cared for in hotels and then expelled under the CDC Order.

10. As described below, ORR has implemented robust COVID-19 infection control protocols, which I believe have helped to protect both UAC and ORR and grantee personnel from COVID-19 thus far. ORR's infection control protocols were developed in consultation with CDC, and take into account the relatively low and stable ORR census during the COVID-19 pandemic. Although the ORR network is comprised of many facilities that house and care for UAC in congregate settings, the relatively low and stable ORR census has allowed ORR to implement infection control measures across the ORR network that would be unworkable if the number of UAC referred to ORR were to increase materially above current levels.

11. I anticipate that the September 4 Order will lead to an increase in the number of referrals to ORR. If the number of referrals increases materially, ORR will not be able to safely absorb incoming UAC according to its existing COVID-19 infection control measures, which will increase the risk of introducing COVID-19 into the ORR network, which I understand to be the type of situation the CDC Order was intended to avoid.

12. Indeed, it is my understanding that hotels are used to house Title 42 minors pending their expulsion precisely because hotels furnish accommodations

conducive to an effective quarantine. Specifically, it is my understanding that hotels enable Title 42 minors to be confirmed to individual rooms with closed doors, where each minor has their own sleeping, eating, and bathing facilities. According to CDC guidance, it is ideal to quarantine individuals in private quarters because it eliminates the opportunity for others to come into contact with surfaces that may have been contaminated with respiratory droplets produced the quarantined individual, such as doorknobs, faucet handles, and other high-touch surfaces.[1]

13. Under the September 4 Order, hotels are no longer an option for temporarily housing Title 42 minors pending their expulsion. As a result, Title 42 minors who would have been housed in hotels Order will now be referred to ORR.

14. As the number of UAC in the ORR network increases, ORR will gradually lose the extra space that must be held in reserve to quarantine or isolate UAC as needed, and ORR will be forced to house UAC in denser conditions, which will further increase the risk of transmission of COVID-19.

[1] *See* CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (updated July 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html ("In order of preference, multiple quarantined individuals should be housed: IDEAL: Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully."); *see also* CDC, Guidance for Shared or Congregate Housing, https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html (last updated Aug. 3, 2020) ("If possible, designate a separate bathroom for residents with COVID-19 symptoms.").

15. Furthermore, immediate implementation of the September 4 Order will require ORR to abruptly transfer hundreds of UAC currently housed in shelters along the Southwest border further inland, in order to make room to medically stage additional incoming UAC in facilities along the Southwest border. This will require UAC and ORR personnel to travel long distances on common carriers, such as airplanes, creating additional risk of infection. The movement of so many UAC across the ORR network also increases the risk of introducing COVID-19 into the shelters that receive transferred UAC, and the communities where those shelters are located.

16. I am concerned that once implementation of the September 4 Order begins, the operational complexity of the implementation will have the unintended consequence of increasing the danger of COVID-19 within the ORR network.

Material changes in the ORR operating environment will negatively impact the program

17. At this point in time, ORR is implementing infection control measures across its system in response to the COVID-19 pandemic, and the system-wide census (that is, the number of UAC in the system) is low relative to the maximum capacity of the system when there is no pandemic. It is also low relative to the historical highs in the census when there is no pandemic. The relatively low census

has remained relatively stable for months. ORR attributes the current operating environment to the CDC Order.

18. My experience is that a host of factors can impact ORR operations. Some of those factors are within ORR's control. Others are not. ORR does not, for example, control the number of referrals of UAC that it receives from DHS; the home countries, demographics, or clinical presentations of the UAC referred by DHS; the numbers or locations of potential sponsors for the UAC; the public health situation domestically or internationally; the public health measures implemented by individual U.S. states or transportation companies (e.g., commercial airlines) in response to the COVID-19 pandemic; and natural disasters that take ORR shelters offline (e.g., recent hurricanes in Texas and Louisiana). ORR can control the public health measures that it implements within its system—as well its decisions concerning the placement and release of UACs—within the operating environment that is presented to ORR and is outside of ORR's control.

19. My best programmatic judgment is that the relatively low and stable census in recent months has given ORR needed operational flexibility to effectively implement infection control measures—and make prompt and safe placement and release decisions—across the system. ORR has, for example, been able to isolate or quarantine confirmed or suspected cases of COVID-19, respectively, among the UAC population as they arise. These measures have protected the health and safety

of UAC in ORR's care and custody and prevented the development of more serious public health concerns in ORR shelters.

20. It would increase the risks to the federal and grantee staff who care for the UAC if there were a material increase in UAC referrals or the percentage of UACs who have tested positive for COVID-19 or been exposed to the disease; the complexity of ORR operations would increase as well and have a potentially negative impact on the effectiveness of the infection control measures in ORR shelters. Indeed, under the current infection control measures, there are limits to the number of UAC that ORR can safely absorb into the system at any one time. A breakdown in the operationalization of the infection control measures—triggered by a large volume of referrals or shift in the clinical presentations of UACs—would increase the danger of COVID-19 for newly-referred UACs and those presently in the system.

21. The health and safety of federal and grantee staff is critical because the loss of staff to sickness or self-quarantine diminishes the capacity of ORR to care for UAC. ORR already loses dozens of staff each week to self-quarantine for COVID-19 because of state and local rules that mandate self-quarantine when traveling between U.S. jurisdictions with high rates of community transmission. When members of the staff transport UAC to sponsors as part of the release process, many become temporarily unavailable regardless of whether they have actually

become infected with or exposed to COVID-19. Any outbreaks in ORR shelters that might result from increases in the census or breakdowns in infection control measures would put additional stress on program operations. Sadly, there have also been several staff deaths associated with COVID-19 during the pandemic; rigorous adherence to infection control measures is important to maintaining morale and the ability to recruit and retain new staff during this challenging time.

22. My best programmatic judgment is that the ORR system would likely come under significant stress if ORR were to begin to receive on a regular basis approximately 75 to 100 referrals of UAC per week, with approximately 30% of the UAC having tested positive or been exposed to COVID-19. The compounding of that stress by other factors outside of ORR's control—such as a material shift in the demographics of UAC referrals towards younger children, which would limit the number of licensed facilities capable of caring for such children—would likely worsen the situation and jeopardize ORR's ability to maintain effective infection control measures. If the September 4 Order becomes effective, and the volume of referrals to ORR increases in kind, then the risk of such a scenario and the attendant consequences would increase dramatically.

The COVID-19 pandemic presents unprecedented operational challenges for ORR

23. ORR is the agency charged with the care and custody of UAC pursuant to 8 U.S.C. § 1232(c) and other provisions. As such, ORR is committed to providing for the safety and well-being of all UAC in its care, as well as protecting the health and safety of the communities in which these children live—including from the risk of COVID-19.

24. To carry out its mission, ORR relies on a network of grantee care-provider facilities located across the country. There are a total of 107 facilities in the ORR grantee care-provider network that house UAC in a congregate setting.

25. ORR has experience with the identification, mitigation, and treatment of communicable diseases affecting UAC, including seasonal influenza (flu), mumps (parotitis), chicken pox (varicella), and tuberculosis. ORR has policies pertaining to communicable disease control that predate the COVID-19 pandemic. ORR's general, long-standing policies concerning the management of communicable disease require the routine assessment of travel history when a child arrives at a care-provider program; medical screenings and vaccinations within 48 hours of arriving at ORR shelters; ability to isolate or quarantine individuals for the purpose of communicable disease control; hand hygiene and respiratory etiquette education efforts; and established communicable disease reporting to the local health authority.

26. The operational challenges presented by the COVID-19 pandemic far exceed those presented by other communicable diseases in the past. Previously, when ORR needed to address infection prevention and control, it was in response to isolated cases or outbreaks in individual facilities, where the cause typically was an already-infected UAC. Other instances involved localized outbreaks in communities where ORR facilities are located. ORR and its care providers have never before confronted a situation where all incoming UAC increased the danger of the introduction of a quarantinable communicable disease into the United States, [2] or where the same quarantinable communicable disease posed a risk to the current UAC population and ORR and grantee personnel based on the community transmission of that disease in locations where ORR facilities are located. Likewise, ORR and its care providers did not originally structure the physical plants or ordinary operations of their facilities to address the challenges presented by the COVID-19 pandemic; the pandemic has required substantial and novel adjustments in the use, operations, and capacity of facilities by ORR and its care providers. In these respects, the COVID-19 pandemic has been unprecedented in the history of the program.

[2] *See* Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060 (Mar. 26, 2020) (effective Mar. 20, 2020) (determining that "covered aliens" who have traveled through Mexico pose a risk of introducing COVID-19 into the United States due to the prevalence of COVID-19 in Mexico).

ORR's infection control measures are workable and safe with a stable and low census

27. Since the first reports of COVID-19 in the U.S., ORR has monitored the public health reporting on COVID-19 in the jurisdictions in which grantee care-provider facilities operate. ORR has provided regular updates to grantee care-provider facilities on infection prevention and control, and issued guidance regarding the screening and management of UAC, facility personnel, and visitors who have potentially been exposed to COVID-19. All of these measures are rooted in guidance from CDC.

28. Personnel from ORR's Division of Heath for Unaccompanied Children (DHUC) began consulting with CDC to develop COVID-19 infection control measures that could be implemented across the ORR network, notwithstanding the variation in physical structures, staffing, and operations across ORR care provider facilities. Specifically, DHUC, including DHUC Director Dr. Michael Bartholomew, consulted with relevant subject matter experts from CDC, including Dr. Amanda Cohn, who reviewed ORR's guidance to care provider facilities on COVID-19 to confirm that it aligned with CDC's guidelines and recommendations, and the best practices for preventing and controlling the spread of COVID-19 within residential facilities. This includes guidance related to symptom and temperature monitoring of staff and children, cleaning and hygiene guidance, and ensuring the ability to isolate ill UAC and quarantine potentially

exposed UAC. *See* Decl. of A. Cohn, *Lucas R. v. Azar*, No. 2:18-cv-5741 DMG (PLAx), Dkt. No. 230-11 (Mar. 27, 2020) (describing CDC's consultation with ORR).

29. To prevent those who may have been exposed to or infected with COVID-19 from entering ORR facilities, ORR has mandated that all visitors and staff seeking to enter any grantee care-provider facility answer COVID-19 screening questions and submit to a mandatory temperature check. With the exception of UAC who are being processed for admission, grantee care-provider facilities are required to deny access to anyone with a fever of 100°F or above; or who exhibits signs of symptoms of an acute respiratory infection, such as a cough or shortness of breath; or who has had contact with someone with a confirmed diagnosis of COVID-19 in the previous 14 days; or who has been tested for COVID-19 and is awaiting test results; or who, in the previous 14 days, has traveled to a country identified by CDC as having widespread, sustained community transmission of COVID-19.

30. In addition, UAC entering ORR care are screened for COVID-19 exposure or symptoms during their initial medical examination ("IME"), which has been expanded to include a COVID-19 health screening protocol consistent with CDC COVID-19 guidelines.

31. UAC at risk of COVID-19 exposure based on reported travel history, but without symptoms, are quarantined and monitored for 14 days. UAC who exhibit COVID-19 symptoms during their IME are isolated and tested in consultation with the local health authority.

32. ORR has also instituted a symptom-monitoring regime to ensure that any UAC in any facility who begins exhibiting potential symptoms of COVID-19 after their IME is immediately identified and appropriately isolated in consultation with the local health authority.

33. Since March 19, 2020, ORR has required each grantee care-provider facility to monitor the temperature of every UAC in care. UACs' temperatures are taken twice daily, once in the morning and again in the evening, and are recorded in a master census temperature report that each facility is required to maintain. If any UAC is found to have a temperature above 100°F, the grantee care-provider is required to immediately alert ORR. The grantee care-provider is required to alert ORR each day that any child has a temperature over 100°F. So for example, if a UAC has a 101°F fever for three days, ORR will be alerted of this fact every day for the duration of the child's fever. Early identification of potential COVID-19 cases allows for early introduction of appropriate public health measures.

34. Any UAC exhibiting symptoms consistent with COVID-19, such as coughing, fever, or difficulty breathing, at any point during their time in ORR care

are to be immediately isolated and referred for evaluation by a licensed medical provider, in consultation with the local health authority. If a UAC is recommended for testing by the healthcare provider or public health department, the UAC is tested.

35. The same isolation procedures are used for any UAC determined to be at risk for COVID- 19 exposure or infection, whether based on information collected during the IME, or through subsequent monitoring. The affected UAC will be provided with a private room, with a closed door and bathroom access, preferably a private bathroom that is not used by other staff or UAC. State and local health departments, along with DHUC are immediately notified and consulted for additional guidance on risk assessment, symptom monitoring, and isolation or quarantine.

36. Facility personnel who enter an occupied isolation room are required to wear personal protective equipment, including an N95 respirator and goggles or a face shield, per CDC guidelines. If a UAC in isolation needs to leave the isolation room for any reason (e.g., to attend a medical appointment, etc.), the UAC must wear a surgical mask for the duration of their time outside the isolation room.

37. If a UAC must be transported to a health clinic or other off-site location, the facility must notify the local health department for guidance on proper precautions during transport. The facility is also required to alert the intended

destination so that proper infection control measures may be implemented prior to the UAC's arrival.

38. UAC are required to remain in isolation until cleared by the local health department or DHUC. During this time in isolation, UAC receive the same services as their non-isolated peers in the same facility, although services—particularly education services—may be adjusted to accommodate proper infection-control procedures.

39. Program staff will provide an affected UAC with notice of the isolation requirement and address questions or concerns the child may have about medical isolation, as well as potential delays to anticipated transfers or discharge plans. In order to protect the health of UAC and the local community, UAC cannot be transferred either to another facility or released to a sponsor until cleared by local health authorities and DHUC.

40. In my judgment, these infection control measures have protected the health and safety of UAC and federal and grantee staff alike. As I discuss more fully below, the ORR system has had to manage UAC and staff who have tested positive for COVID-19 or been exposed to the disease. The management of those situations pursuant to ORR's infection control measures has succeeded in preventing more serious public health concerns from developing in ORR facilities.

41. In my judgment, ORR has been able to implement the infection control measures effectively due in part to its system-wide census during the COVID-19 pandemic. The system-wide census during the pandemic has been far less than either ORR's maximum capacity or historical highs.

42. As of September 8, 2020, there are a total of 1,097 UAC in ORR care. This includes 409 UAC in long-term foster care and 139 UAC in transitional foster care, which are not congregate settings. For congregate settings only, there are 515 UAC in shelter facilities.

43. Currently, ORR's care-provider facilities are operating below their maximum capacity and historical highs. For example, at this time last year (August/September of 2019), ORR was receiving approximately 2,779 monthly referrals and had almost 5,039 minors in care with a 41% occupancy rate (including influx and variance beds). In contrast, August 2020 referrals were approximately 423 with approximately 972 minors in care, and an 8% occupancy rate (including influx and variance beds).

44. Critically, based on the August 2020 referrals, ORR is already receiving approximately 105 referrals a week, which is the upper limit of referrals ORR can safely absorb while maintaining COVID-19 infection prevention protocols. Thus, ORR is already at its functional intake capacity. It is my understanding that DHS anticipates that it may need to refer approximately 60-140

additional minors to ORR per week after the September 4 Order takes effect and DHS can no longer house minors in hotels.

45. Thus, I anticipate that ORR will immediately begin receiving approximately 165 to 245 referrals a week from DHS once the September 4 Order becomes effective, which exceeds the threshold of 75 to 100 referrals a week that ORR can safely absorb according to its COVID-19 infection prevention protocols.

46. Although ORR has a large number of available beds on paper, the majority of these beds are located in congregate facilities, where UAC live in dormitory-like conditions, with shared sleeping, eating, and bathing facilities. ORR cannot use its full capacity to shelter UAC without jeopardizing its ability to maintain its current infection control measures. Moreover, many of the available beds are in shelters located in the interior of the United States, and ORR could not utilize them without transporting UAC from the U.S.-Mexico border region, through multiple states, to the shelters. This would increase the risk of COVID-19 exposure for UAC and federal and grantee staff alike, in addition to leading to reductions in ORR operational capacity due to subsequent self-quarantines of returning staff. The relatively stable, historically low system-wide census within ORR facilities during the COVID-19 pandemic has allowed ORR the operational flexibility that it needs to implement infection control measures effectively.

Careful placement and release decisions are another key part of the COVID-19 response

47. ORR is continually monitoring the jurisdictions in which its grantee care-provider facilities operate to determine whether the conditions in the community surrounding the facility warrant the suspension of placements due to concerns related to COVID-19. For example, beginning on March 9, 2020, ORR stopped placements of UAC on a rolling basis in the states of California, New York, and Washington due to the ongoing outbreaks of COVID-19 among the general public in those states.

48. In addition, ORR is prioritizing local placements for all new referrals from DHS in order to limit the need for UAC to travel on commercial airliners, which poses a risk of exposing passengers (including UAC) to COVID-19. Care providers may still use air travel to reunify a UAC with their sponsor if it is safe to do so. But care providers are required to assess the safety of the UAC's ultimate destination, in order to anticipate logistical issues associated with the COVID-19 pandemic. Care-provider facilities are required to consult with their Federal Field Specialist ("FFS"), or delegate, if a UAC will be traveling to a jurisdiction with widespread community transmission of COVID-19 or that is subject to a community-wide "lock down." In such cases, release should be postponed until it is deemed safe, which may be an undetermined and lengthy period, further burdening ORR capacity. This safety assessment includes consideration of the

particular UAC's unique medical needs and vulnerabilities, and the UAC's respective medical specialists are consulted in the safety planning process.

49. The increased operational complexity associated with placement and release decisions during the COVID-19 pandemic is yet another reason why a stable and low census is important to the effective implementation of infection control measures within the ORR system. ORR cannot utilize its full capacity during the COVID-19 pandemic without jeopardizing its ability to maintain effective infection control measures. At the same time, ORR must account for an array of public health concerns whenever it moves UAC into and out of ORR facilities. A stable and low census gives ORR the operational flexibility that it needs to make placement and release decisions that are not only prompt but also safe for UAC and the public.

COVID-19 has already impacted ORR care-provider facilities

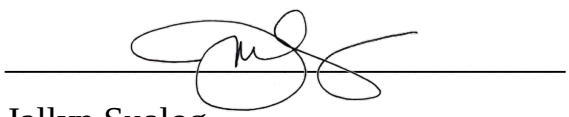
50. Despite the robust measures described above, COVID-19 has still impacted ORR. As of September 8, 2020, there have been a total of 204 confirmed COVID-19 cases among UAC across all ORR care-provider facilities since March 24, 2020, when the first infection of a UAC was reported in a facility in New York. Currently, there are 65 active cases. Active cases are primarily in Texas, where ORR within the last two weeks received over 100 referrals of UAC infected with or exposed to COVID-19. These UAC are currently in isolation, per ORR and CDC guidelines, and are receiving appropriate monitoring and medical care. Even if

some eventually test negative, they must be presumed positive and cared for as such until results are available.

51. In addition, a total of 745 program staff and contractors have self-reported testing positive for COVID-19 since March 18, 2020. The majority of infected staff are in Texas, Arizona and New York. ORR has received reports that four (4) facility staff members and one (1) foster parent have died as a result of COVID-19. ORR's medical team and the affected programs have worked in close coordination with the local public health departments on appropriate public health measures for staff members, which typically involve self-quarantine at home, and the tracking and monitoring of the affected staff members' contacts within the care-provider facility, per CDC guidance.

52. In addition to the COVID-19 protocols described above, care-provider facilities are directed to follow any local requirements issued by the state licensing agency or other local public health authority related to the identification, reporting, and control of communicable diseases that are more stringent than ORR's protocols.

Executed on September 11, 2020.



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