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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

12

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14 Jane Doe #1; Jane Doe #2; Norlan
FLORES, on behalf of themselves and
15 all others similarly situated,

16 Plaintiffs,
v.

17 Jeh Johnson, Secretary, United States
18 Department of Homeland Security, in his
official capacity; R. Gil Kerlikowske,
19 Commissioner, United States Customs &
Border Protection, in his official
20 capacity; Michael J. Fisher, Chief of the
United States Border Patrol, in his
21 official capacity; Jeffrey Self,
Commander, Arizona Joint Field
22 Command, in his official capacity;
Manuel Padilla, Jr., Chief Patrol Agent-
23 Tucson Sector, in his official capacity,

24 Defendants.

25

26

27

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Case No. 4:15-cv-00250-TUC-DCB

**DECLARATION OF JOE
GOLDENSON, M.D. IN SUPPORT
OF PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

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25 * Admitted pursuant to Ariz. Sup. Ct. R. 38(a)
26 ** Admitted pursuant to Ariz. Sup. Ct. R. 38(f)

1 I, JOE GOLDENSON, M.D., submit the following declaration on behalf of Plaintiffs in
2 support of their Motion for Preliminary Injunction:

3 **I. BACKGROUND**

4 1. I am a medical physician with 28 years of experience as the
5 Director/Medical Director for Jail Health Services for the San Francisco Department of
6 Public Health. In that role, I provided direct clinical services and managed the
7 correctional health enterprise, including the budget, human resources and medical, mental
8 health, dental and pharmacy services.

9 2. I am currently a member of the Board of Directors of the National
10 Commission on Correctional Health Care and past President of the California chapter of
11 the American Correctional Health Services Association.

12 3. I have worked extensively as a correctional health medical expert and court
13 monitor. I am currently one of the medical experts retained by the federal district court
14 *Plata v. Brown*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to
15 inmate patients in the California Department of Correctional Rehabilitation. I have been a
16 medical expert/monitor for Cook County Jail in Chicago, as well as in jails in
17 Washington, Texas, and Florida, and in State Departments of Corrections in Illinois, Ohio,
18 and Wisconsin.

19 4. A true and correct copy of my current resume is attached as Attachment A
20 to this report.

21 5. I have been retained to consult with Plaintiffs' counsel, review documents
22 and other information, prepare declarations, and be available to testify regarding my
23 opinions on behalf of Plaintiffs in connection with litigation brought against Defendants.

24 6. I have been asked to render opinions concerning the medical screening and
25 medical care of detainees in U.S. Customs and Border Protection facilities within the
26 Tucson Sector of the U.S. Border Patrol, and related matters as discussed in this
27 declaration.
28

1 **II. MATERIALS CONSIDERED**

2 7. In forming my opinions, I reviewed documents produced by Defendants in
3 this case, including documents related to medical screening and medical care of detainees
4 in U.S. Customs and Border Protection facilities within the Tucson Sector of the U.S.
5 Border Patrol.

6 8. I also reviewed the declarations of individuals who were formerly detained
7 in U.S. Customs and Border Protection facilities within the Tucson Sector of the U.S.
8 Border Patrol submitted in support of Plaintiffs’ Motion for Class Certification.

9 9. I am informed that sanitarian Robert Powitz and corrections expert Eldon
10 Vail personally inspected all four of the Border Patrol Stations made available to Plaintiffs
11 for inspection—Tucson, Casa Grande, Douglas and Nogales—on September 8 through
12 September 11, 2015. I have read the declarations of Robert Powitz and Eldon Vail
13 submitted in support of Plaintiffs’ Motion for Preliminary Injunction. Specifically, Mr.
14 Vail reports that he was told by Defendants’ personnel, during these inspections, that no
15 medical screening is conducted at any of these facilities. (Decl. of Eldon Vail (“Vail
16 Decl.”) In Support of Motion for Preliminary Injunction ¶ 138.)

17 10. I also reviewed the declaration of Joseph Gaston, data analyst at Morrison &
18 Foerster LLP, regarding “e3DM” spreadsheet data produced by Defendants, which
19 purportedly reflects Defendants’ logging system that tracks certain data points for
20 detainees confined in a U.S. Customs and Border Protection facility within the Tucson
21 Sector of the U.S. Border Patrol. (Decl. of Joseph Gaston in Support of Motion for
22 Preliminary Injunction.) Specifically, I reviewed the analysis related to any indications of
23 medical treatment of detainees held in a facility within the Tucson Sector. (*Id.* ¶¶ 54-55.)

24 **III. MEDICAL SCREENING STANDARDS IN DETENTION SETTINGS**

25 11. The National Commission on Correctional Health Care (“NCCHC”) is an
26 organization that sets widely recognized standards for health services in correctional
27 facilities. Informed by health, legal, and corrections professions, NCCHC establishes
28 Standards for the management of a correctional health services system. Written in

1 separate volumes for prisons, jails and juvenile confinement facilities, plus a manual for
2 mental health services and another for opioid treatment programs, the Standards cover the
3 areas of care and treatment, health records, administration, personnel and medical-legal
4 issues. Since the 1970s, NCCHC offers an accreditation program based on its Standards,
5 to determine whether correctional institutions meet the standards in provision of health
6 services.

7 12. Among its other Standards, NCCHC has established a Receiving Screening
8 Standard to take place for all detainees as soon as they are admitted into a facility, by
9 qualified health care professionals or health-trained correctional officers. (Ex. 202.)¹

10 13. Consistent with this Standard, medical intake in a detention setting consists
11 of two components: (1) immediate medical triage to determine if there are any issues that
12 would preclude acceptance into the facility and (2) a more thorough medical and mental
13 health screening. In many facilities, this is a two-step process with medical triage
14 performed upon entry into the facility, and the more thorough screening soon after the
15 person has been accepted into the facility.

16 14. This screening includes both a face-to-face interview using a structured
17 questionnaire and, whenever possible, a review of the individual's prior medical record.
18 The questionnaire enquires into an individual's current problems and medications; past
19 history, including hospitalizations; mental health history, including current or past suicidal
20 ideation; symptoms of chronic illness; medication and/or food allergies; and dental
21 problems. For female detainees, it is important to obtain a history of current and past
22 pregnancy, as well as the date of last menstrual period.

23 15. Whenever possible, intake screening is performed by qualified health
24 professionals. In smaller detention settings, where health care staff is not present at all
25 times, specially trained custodial staff conducts the intake screening.

27 ¹ All exhibits referenced in this declaration are to the Appendix of Exhibits In Support of
28 Plaintiffs' Motion for Preliminary Injunction.

1 16. Training given to correctional officers who conduct the receiving screening
2 is a crucial aspect of the process. At a minimum, they should receive periodic training on
3 taking a medical history, making necessary observations, documentation of findings,
4 appropriate actions to take for common medical and mental health issues, and medical
5 confidentiality. There must also be a procedure for officers to obtain guidance and
6 direction from a health care professional for problems beyond the scope of their training
7 and experience.

8 17. Finally, information obtained as part of the screening process should be kept
9 as accessible records so that a detention facility has information regarding the medical
10 status of individuals in its custody, and can provide that information to health care
11 professionals as needed.

12 **IV. FAILURE TO SCREEN AT TUCSON SECTOR CBP FACILITIES**

13 18. U.S. Customs and Border Protection has adopted limited policies related to
14 medical screening. For example, Section 4.3 of the “U.S. Customs and Border Protection
15 National Standards on Transport, Escort, Detention, and Search” states that “[u]pon a
16 detainee’s entry into any CBP hold room, officers/agents must ask detainees about, and
17 visually inspect for any sign of injury, illness, or physical or mental health concerns and
18 question the detainee about any prescription medications.” (Ex. 95 at USA000631.) It
19 also states that “Observed or reported injuries or illnesses should be communicated to a
20 supervisor, documented in the appropriate electronic system(s) of record, and appropriate
21 medical care should be provided or sought in a timely manner.” (*Id.*)

22 19. According to the statements from Defendants’ personnel during the
23 inspections performed by Plaintiffs and their experts, as well as the declarations of former
24 detainees submitted in this case, however, medical screening is not performed at these
25 facilities in the Tucson sector.

26 20. As explained above, Mr. Vail reports that he was told by Defendants’
27 personnel that no medical screening is conducted at any of these facilities. (Vail Decl. ¶
28 138.)

1 21. The declarations of former detainees are consistent with this representation
2 that there is no medical intake screening performed at these facilities. For example, Odilla
3 Velasquez Vasquez was detained by Border Patrol and transported to the Douglas Border
4 Patrol Station and held in a cell for 18 hours. (ECF No. 2-2, Ex. 19 ¶ 7.) Ms. Vasquez
5 declared that when she arrived with her daughter to the facility “we were never asked
6 about our health nor given a formal medical exam.” (*Id.* ¶ 19.) And when she asked
7 officials at the facility for help and explained that her daughter had an ear infection, they
8 said “there is no medicine here.” (*Id.*)

9 22. Valdemar Perez Perez and his son were also held at the Douglas Station, for
10 16 hours, before being transferred to the Tucson Border Patrol Station and detained in that
11 station in a cell for 20 hours. (ECF No. 2-2, Ex. 21 ¶¶ 7, 18.) Neither Mr. Perez nor his
12 son was given a formal medical exam or asked about his medical health. (*Id.* ¶ 24.)

13 23. The declarations of numerous other former detainees confirm that these
14 facilities do not have appropriate medical screening as part of the intake process. (*E.g.*,
15 ECF No. 2-2, Ex. 30 ¶ 20 (no medical screening despite both her and her 2 year old son
16 having bad coughs); *id.*, Ex. 29 ¶¶ 19, 24 (no medical screening despite 1.5 year old
17 daughter having stomach pain); *id.*, Ex. 28 ¶ 30 (no medical screening despite her two
18 children feeling sick); ECF No. 2-3, Ex. 42 ¶ 9 (no medical screening and, after disclosing
19 she was pregnant, agents insulted her, poked her stomach, and contended she was not
20 pregnant); ECF No. 2-1, Ex. 16 ¶ 16 (was not asked about her health despite being five
21 months pregnant); ECF No. 2-2, Ex. 23 ¶ 7 (no medical screening upon entry to facility);
22 ECF No. 2-3, Ex. 36 ¶ 25 (same).)

23 **V. FAILURE TO SCREEN PUTS DETAINEES AT MEDICAL RISK**

24 24. Medical screening during the intake process at a detention facility is one of
25 the most essential components of the health care program in a detention setting.
26 Correctional officers who conduct such screening are the gatekeepers—this process
27 ensures the safety of both detainees and staff. All individuals entering a detention facility,
28 whether newly apprehended or transferring from another facility, must be screened so that

1 correctional staff are aware of the medical and mental health of each individual entering
2 detention and are able to respond appropriately, including enlisting assistance of medical
3 professionals whenever this is necessary.

4 25. Any screening conducted in the field prior to an individual's arrival at a
5 detention facility is not an adequate replacement for this intake screening process for a
6 variety of reasons. First, it is unclear whether agents in the field receive sufficient
7 medical training to make determinations regarding the medical and mental health
8 conditions of apprehended individuals. Second, nothing in Defendants' production
9 suggests that field screening is standardized by any protocol or procedure.

10 26. Moreover, a significant period of time lapses between the time of
11 apprehension and the time of admission into a detention facility—which provides an
12 opportunity for the conditions of a detainee to change.

13 27. Lastly, it does not appear that any such screening is documented, or that
14 written documentation is transferred to the detention facility. Without the appropriate
15 recordkeeping, any such screening is useless to understand the medical conditions of each
16 detainee and the medical risks for the facility once that individual is admitted.

17 28. Intake screening is so critical because it allows staff to determine whether
18 newly arriving detainees have any urgent or emergent health care needs; are suffering
19 from a potentially communicable disease requiring isolation and enhanced disinfection
20 processes following their transfer or release; are receiving medications that must be
21 continued; or have medical or mental health conditions that require referral for follow-up.

22 29. Failure to perform medical screening at intake puts detainees at medical risk
23 across all of these areas. Individuals with urgent or emergent health care needs often
24 require care that cannot be adequately provided in a detention facility or by correctional
25 officers without medical training and certification. If individuals are not screened at
26 intake, those with urgent or emergent medical problems may not be promptly identified
27 and sent to an outside medical facility or emergency room for care and clearance.
28

1 30. Failure to adequately screen detainees also puts these individuals—and staff
2 at the facility—at additional medical risk of infectious disease. The spread of infectious
3 diseases is a substantial health and public health concern in a detention setting.
4 Documents from the Tucson Coordination Center show that highly contagious skin
5 diseases, like scabies, are an issue for facilities in the Tucson sector. (Ex. 84 at
6 USA00167 (“We must be prepared for the onslaught of Scabies, Chiggers and other bites
7 and bumps.”).) Given the proximity of physical space in which individuals are detained,
8 unidentified infectious diseases can create an emergency health care issue that a detention
9 facility is not equipped to address. Moreover, if unrecognized and untreated prior to
10 release, these individuals pose a serious public health threat when they are released.

11 **VI. DETAINEES IN TUCSON SECTOR CBP FACILITIES HAVE HIGHER**
12 **MEDICAL RISK**

13 31. The risk associated with CBP’s failure to perform adequate medical
14 screening is escalated by the condition of detainees arriving in the Tucson Sector
15 facilities. The journey for individuals attempting to cross the Tucson border is often one
16 of extreme physical hardship—extended physical exertion from walking, lack of sufficient
17 water and food, and no access to medications and other medical supplies.

18 32. For example, former detainee Maria Lorena Lopez Lopez describes in her
19 declaration that the group she was with “had been abandoned in the desert for
20 approximately one week without enough food or water, so I was relieved when Border
21 Patrol found us.” (ECF No. 2-2, Ex. 23 ¶ 5; *see also, e.g., id.*, Ex. 29 ¶¶ 3, 16, 19 (mother
22 and 1.5 year old daughter had not eaten in four days before they were detained); ECF No.
23 2-3 ¶¶ 3, 12 (mother and two year old daughter had been walking for 15 hours in the
24 desert, were cold, hungry, tired, and suffering from headache and earache pain before they
25 were detained); *id.*, Ex. 35 ¶ 13 (mother and three year old daughter had not eaten for a
26 day before they were detained); ECF No. 2-1, Ex. 16 ¶ 3 (mother with 10 year old
27 daughter and 8 year old son had not eaten for a day before they were detained).)
28

1 33. The former detainee declarations describe how these conditions can
2 continue throughout an individual's detention in a Tucson Sector facility, including being
3 held in detention for 12 or more hours without provision of adequate food and water. For
4 example, Anselma Angela Ambrosio Diaz and her 7 year old son were detained at the
5 detention facility in Douglas for one night and then transferred to the Tucson facility.
6 (ECF No. 2-1, Ex. 5 ¶¶ 3, 14, 16.) They were detained for almost 24 hours but did not
7 receive any food or drinking water, only two small juice boxes each. (*Id.* ¶¶ 13, 17.)

8 34. Jesus Alfredo Mesa Barbosa was held in a cell for 16 hours at the Nogales
9 facility. (ECF No. 2-3, Ex. 43 ¶¶ 4, 22.) He was not given any food or drinking water
10 during that time. (*Id.* ¶¶ 18-19.) He was then transferred to the Tucson facility where he
11 was detained for three days. (*Id.* ¶ 22.) For the next two days, he continued to be held
12 without food and water (*id.* ¶ 28, 32), which he finally received on his final day at the
13 Tucson facility (*id.* ¶ 38, 39).

14 35. The former detainee declarations also evidence the unhygienic and
15 unsanitary conditions of the holding cells or detention rooms in Tucson Sector facilities.
16 (*See, e.g.*, ECF No. 2-1, Ex. 5 ¶¶ 10, 12, 15 (no soap or way to wash hands at either
17 Tucson or Douglas facility, while 6 year old boy also in cell at Douglas became sick
18 during the night and was vomiting); *id.*, Ex. 9 ¶ 28 (used toilet paper scattered on ground
19 in cell, no waste container); *id.*, Ex. 8 ¶ 11 (diapers and toilet paper strewn around toilet in
20 cell, no waste container).)

21 36. The lack of sufficient hydration and nutrition both prior to and during
22 detention in a Tucson Sector facility, coupled with the hygiene and sanitation issues in
23 each of these facilities, puts detainees at higher medical risk.

24 37. Severe dehydration is a medical emergency and requires immediate medical
25 attention. Prolonged lack of water can result in severe dehydration. Potential
26 complications of dehydration are heat stroke, seizures, shock, kidney failure, coma, and
27 death.

28

1 38. Inadequate hygiene can cause outbreaks of serious medical illnesses such as
2 food poisoning, amebic dysentery, hepatitis, and skin infections, such as life-threatening
3 staphylococcal infections.

4 39. Under these circumstances, medical screening to identify and address urgent
5 or emergent medical issues is even more critical.

6 **VII. ACCESS TO MEDICAL CARE AT TUCSON SECTOR CBP FACILITIES**

7 40. In addition to its provisions regarding medical screening, Section 4.3 of the
8 “U.S. Customs and Border Protection National Standards on Transport, Escort, Detention,
9 and Search” states that “[o]bserved or reported injuries or illnesses should be
10 communicated to a supervisor, documented in the appropriate electronic system(s) of
11 record, and appropriate medical care should be provided or sought in a timely manner.”
12 (Ex. 95 at USA000631.)

13 41. The documents produced by Defendants also suggest that facilities in the
14 Tucson Sector rely upon emergency rooms and ambulance staff for medical care of
15 detainees, as there are usually not health care professionals on staff at these detention
16 facilities. (Ex. 84 at USA000164 (“Any subject that requests medical attention, or visible
17 [sic] appears to need medical attention should be evaluated by an EMT. If there is not an
18 EMT on duty then the subject should be taken to University Medical Center – South
19 Campus for treatment.”).)

20 **VIII. FAILURE TO PROVIDE ACCESS TO MEDICAL CARE AT TUCSON** 21 **SECTOR CBP FACILITIES**

22 42. According to the declaration of data analyst Joseph Gaston, the e3DM data
23 shows that between June 10, 2015 to September 28, 2015, there were approximately 527
24 incidents of medical treatment reportedly provided to a detainee, out of 17,006
25 “deportable aliens” detained at U.S. Customs and Border Protection facilities within the
26 Tucson Sector of the U.S. Border Patrol. (Decl. of Joseph Gaston in Support of Motion
27 for Preliminary Injunction ¶ 54.)
28

1 43. But numerous declarations of former detainees in different facilities indicate
2 a practice that is contrary to the U.S. Customs and Border Protection National Standards
3 regarding the provision of medical care: officers ignore medical issues raised by
4 detainees, as well as their explicit requests for medical attention.

5 44. For example, Maria Lorena Lopez Lopez declares that upon her arrival at
6 the Naco Border Patrol station: “I did not receive a medical evaluation, even though I was
7 experiencing heavy, sustained vaginal bleeding.” (ECF No. 2-2, Ex. 23 ¶ 7.) “I asked for
8 medical attention but the agents said was just my period and gave me some tampons. I
9 was very worried about my health but I did not receive a medical examination until after I
10 was transferred to ICE custody, approximately five days later.” (*Id.*)

11 45. Luis Carlos Valladares Martinez was detained in Agua Prieta and
12 transported to the Douglas Border Patrol station, where he was kept in a cell for
13 approximately two days and two nights, then transferred to the Tucson station and kept in
14 a cell for another eight hours. (ECF No. 2-3, Ex. 40 ¶¶ 3-4, 8.) He explains: “I would
15 have liked medical treatment for a large, deep gash I got on my chest when trying to cross
16 the border. But when I showed it to an agent he said it was nothing. I didn’t bring it up
17 again because they don’t listen, they get mad just by us talking.” (*Id.* ¶ 15.)

18 46. Several other former detainees described various injuries and medical
19 conditions for which they requested medical attention but were denied. (*E.g.*, ECF No. 2-
20 3, Ex. 39 ¶ 4 (asked to see a doctor for head pain and sickness, agents said they would
21 call, but no one ever came); ECF No. 2-2, Ex. 19 ¶ 19 (seven year old daughter developed
22 ear infection while in detention, told officials and asked for help but they said “there is no
23 medicine here”); *id.*, Ex. 30 ¶¶ 20, 21 (she and her 2 year old son did not receive medical
24 treatment for severe coughs, and also observed agent tell other detainee reporting illness
25 that he would have to “put up with the sickness because there was no way to get medical
26 attention); ECF No. 2-3, Ex. 35 ¶ 30 (told agent that her head and stomach hurt but agent
27 did not offer medical care, and also observed agent telling woman crying from stomach
28 paid that “it was just because of the hunger or cold and was unimportant and she did not

1 need medical attention”); ECF No. 2-1, Ex. 7 ¶ 17 (another man in cell was suffering from
2 allergy attack, requested help but agents did nothing); *id.*, Ex. 9 ¶ 13 (told guard she had a
3 headache and fever, guard said “I am not a doctor” and that even if he had pills, he would
4 not give them to her); *see also id.*, Ex. 5 ¶ 10 (in cell with 6 yr old boy who was vomiting,
5 with no way to get agents’ attention for help); *id.*, Ex. 11 ¶ 20 (hurt shoulder while
6 walking for 10 days before detention, had no opportunity to access medical care).)

7 **IX. PRESCRIPTION CONTINUATION AND ACCESS TO MEDICATION AT**
8 **TUCSON SECTOR CBP FACILITIES**

9 47. It is standard in detention facilities similar those within the Tucson Sector of
10 the U.S. Border Patrol to have in place a policy maximizing a detainee’s ability to
11 continue prescribed medication.

12 48. For detainees who arrive at Tucson Sector facilities with prescribed
13 medication, Section 4.10 of the “U.S. Customs and Border Protection National Standards
14 on Transport, Escort, Detention, and Search” states that a non “U.S.-prescribed”
15 medication must either be “validated by a medical professional” before it can be self-
16 administered by a detainee, or otherwise that detainee “should be taken in a timely manner
17 to a medical practitioner to obtain an equivalent U.S. prescription.” (Ex. 95 at
18 USA000634.)

19 **X. FAILURE TO PROVIDE PRESCRIPTION CONTINUATION AND**
20 **ACCESS TO MEDICATION AT TUCSON SECTOR CBP FACILITIES**

21 49. Like the policies related to medical care, the declarations of former
22 detainees show that, in practice, officers deny detainee requests for medication, even
23 prescription medication, rather than follow the policies and procedures related to
24 medication in the U.S. Customs and Border Protection National Standards.

25 50. For example, Fernando Munguilla Erasno was detained at the Douglas
26 facility for 24 hours, then transferred to the Sonoita facility for another 24 hours. (ECF
27 No. 2-1, Ex. 6 ¶¶ 8, 18.) Mr. Erasno had a prescription for a heart condition, which
28 causes him to have heart pain and numbness in his left arm. (*Id.* ¶ 15.) While he did not

1 have this prescription with him when he was detained, he told agents about his heart
2 condition. (*Id.*) The agents told him that they could not prescribe anything for him. (*Id.*)
3 He also told the guards about his heart condition at the Sonoita facility, but again the
4 guards said they could not give him anything and that a doctor had to see him first. (*Id.*)

5 51. Maria de Jesus Lopez Magdaleno was detained in a cell at the Nogales
6 facility overnight for 12 hours. (*Id.*, Ex. 9 ¶¶ 5-6.) She states: “I was taking medication
7 for an ovarian cyst that I had been diagnosed with. The guards did not let me take the
8 medication. . . . I was supposed to take the medicine for five days but I had only taken two
9 or three days of the medicine when I was detained and they didn’t let me take any more.”
10 (*Id.* ¶ 14; *see also* ECF No. 2-3, Ex. 35 ¶ 14 (carrying medication for severe migraines and
11 stomach pain which was taken away).)

12 52. Beyond medication that a detainee has been prescribed or is carrying when
13 they are detained, the declarations also show that agents refuse requests for medication
14 based on sickness or pain experienced by individuals while in detention. (*See, e.g.*, ECF
15 No. 2-2, Ex. 25 ¶ 17 (woman detained with her asked for medicine for fever but said they
16 could not give her anything because they were not doctors); ECF No. 2-3, Ex. 36 ¶ 25
17 (she and her 9 and 15 yr old daughters asked for medication for headache pain, agents told
18 them that they did not give out medication).)

19 **XI. FAILURE TO PROVIDE ACCESS TO MEDICAL CARE PUTS**
20 **DETAINEES AT MEDICAL RISK**

21 53. Failure to provide access to medical care and medications, including
22 prescribed medication, imposes obvious but serious medical risks on detainees. Denying
23 or delaying access to medical care for a detainee could exacerbate his or her medical
24 condition and, depending on the condition, could be life threatening.

25 54. Withholding prescribed medication—or access to obtaining that medication
26 through a new prescriber—is particularly serious for those whose medications must be
27 continued in order to avoid urgent health care problems.

28

1 **XII. CONCLUSIONS**

2 55. Based on my review of documents, former detainee declarations, and my
3 understanding from representations by Defendants' personnel during the inspection of the
4 four Border Patrol Stations, it is my opinion that the failure to perform adequate medical
5 screening of detainees and provide adequate access to medical care in U.S. Customs and
6 Border Protection facilities within the Tucson Sector of the U.S. Border Patrol results in
7 serious risk of present or future harm to detainees and staff in these facilities.

8
9 Executed this 4th day of December, 2015.

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12 _____
13 JOE GOLDENSON, M.D.
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Attachment A

CURRICULUM VITAE

**JOE GOLDENSON, MD
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EDUCATION

Post Graduate Training

February 1992 University of California, San Francisco, CPAT/APEX
Mini-Residency in HIV Care
1979-1980 Robert Wood Johnson Fellowship in Family Practice
1976-1979 University of California, San Francisco
Residency in Family Practice

Medical School

1973-1975 Mt. Sinai School of Medicine, New York
M.D. Degree
1971-1973 University of Michigan, Ann Arbor

Undergraduate Education

1967-1971 University of Michigan, Ann Arbor
B.A. in Psychology

PROFESSIONAL EXPERIENCE

Practice Experience

1993-2015 Director/Medical Director
Jail Health Services
San Francisco Department of Public Health
1991-1993 Medical Director
Jail Health Services
San Francisco Department of Public Health
1990-1991 Chief of Medical Services, Hall of Justice
Jail Health Services
San Francisco Department of Public Health
1987-1990 Staff Physician
Jail Health Services
San Francisco Department of Public Health
1980-1987 Sabbatical
1975-1976 Staff Physician
United Farm Workers Health Center, Salinas, CA

Consulting

6/14-9/14	Medical expert for the Illinois Department of Corrections and the ACLU of Illinois
6/10-12/13	Federal Court appointed Medical Monitor, U.S. v. Cook County, et al., 10 C 2946, re: medical care in the Cook County Jail
6/08-6/12	Member, <i>Plata v. Schwarzenegger</i> Advisory Board to the Honorable Thelton E. Henderson, U.S. District Court Judge
5/08-9/09	Medical Expert for ACLU re Maricopa County Jail, Phoenix, AZ
1/08	Member of the National Commission on Correctional Health Care's Technical Assistance Review Team for the Miami Dade Department of Corrections
9/07-1/10	Federal Court appointed Medical Expert, <i>Herrera v. Pierce County, et al.</i> , re: medical care at the Pierce County Jail, Tacoma, WA
8/06-8/12	State Court Appointed Medical Expert, <i>Farrell v. Allen</i> , Superior Court of California Consent Decree re medical care in the California Department of Juvenile Justice
6/05	Member of Technical Assistance Review Team for the Dallas County Jail
11/02-4/03	Medical Expert for ACLU re Jefferson County Jail, Port Townsend, Washington
4/02-8/06	Federal Court Medical Expert, <i>Austin, et. al vs Wilkinson, et al</i> , Class Action Law Suit re: Prisoner medical care at the Ohio State Penitentiary Supermax Facility
4/02-Present	Federal Court Medical Expert, <i>Plata v. Schwarzenegger</i> , Class Action Law Suit re: Prisoner medical care in California State Prison System
1/02-3/02	Consultant to the Francis J. Curry, National Tuberculosis Center re: <i>Tuberculosis Control Plan for the Jail Setting: A Template (Jail Template)</i> ,
8/01-4/02	Medical Expert for ACLU re Wisconsin Supermax Correctional Facility, Boscobel, WI
7/01-4/02	Medical Expert for Ohio Attorney General's Office re Ohio State Prison, Youngstown, OH
1/96-1/14	Member and Surveyor, California Medical Association Corrections and Detentions Health Care Committee
5/95-6/08	Medical Expert for the Office of the Special Master, <i>Madrid vs Alameida</i> , Federal Class Action Law Suit re: Prisoner medical care at the Pelican Bay State Prison Supermax Facility
3/98-12/98	Member, Los Angeles County Department of Public Health Jail Health Services Task Force
2/98	Medical Expert, Department Of Justice Investigation of Clark County Detention Center, Las Vegas, Nevada
6/94	Surveyor, National Commission on Correctional Health Care,

INS Detention Center, El Centro, CA

Work Related Committees

1/14 to present	Member, Editorial Advisory Board, <i>Correctional Health Care Report</i>
10/11 to present	Member, Board of Directors of the National Commission on Correctional Health Care
5/07-10/12	Liaison to the CDC Advisory Council for the Elimination of Tuberculosis (ACET) from the National Commission on Correctional Health Care
12/04-3/06	Member of the CDC Advisory Council for the Elimination of Tuberculosis (ACET) Ad Hoc Working Group on the <i>Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC</i> (MMWR 2006; 55(No. RR-9))
6/03-8/03	Member of the Advisory Panel for the Francis J. Curry National Tuberculosis Center and National Commission on Correctional Health Care, 2003: <i>Corrections Tuberculosis Training and Education Resource Guide</i>
3/02-1/03	Member of the Advisory Committee to Develop the <i>Tuberculosis Control Plan for the Jail Setting: A Template (Jail Template)</i> , Francis J. Curry, National Tuberculosis Center
6/01-Present	Director's Cabinet San Francisco Department of Public Health
3/01	Consultant to Centers for Disease Control on the Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings (MMWR 2003; 52(No. RR-1))
9/97-6/02	Member, Executive Committee of Medical Practice Group, San Francisco Department of Public Health
3/97-3/02	American Correctional Health Services Association Liaison with American Public Health Association
3/96-6/12	Chairperson, Bay Area Corrections Committee (on tuberculosis)
2/00-12/00	Medical Providers' Subcommittee of the Office-based Opiate Treatment Program, San Francisco Department of public Health
12/98-12/00	Associate Chairperson, Corrections Sub-Committee, California Tuberculosis Elimination Advisory Committee
7/94-7/96	Advisory Committee for the Control And Elimination of Tuberculosis, San Francisco Department of Public Health
6/93-6/95	Managed Care Clinical Implementation Committee, San Francisco Department of Public Health
2/92-2/96	Tuberculosis Control Task Force, San Francisco Department of Public Health
3/90-7/97	San Francisco General Hospital Blood Borne Pathogen Committee
1/93-7/93	Medical Staff Bylaws Committee, San Francisco Department of Public Health

ACADEMIC APPOINTMENT

1980-2015 Assistant Clinical Professor
University of California, San Francisco

PROFESSIONAL AFFILIATIONS

Society of Correctional Physicians, Member of President's Council, Past-Treasurer and Secretary
American Correctional Health Services Association, Past-President of California Chapter
American Public Health Association, Jails and Prison's Subcommittee
Academy of Correctional Health Professionals

PROFESSIONAL PRESENTATIONS

Caring for the Inmate Health Population: A Public Health Imperative, Correctional Health Care Leadership Institutes, July 2015
Correctional Medicine and Community Health, Society of Correctional Physicians Annual Meeting, October, 2014
Identifying Pulmonary TB in Jails: A Roundtable Discussion, National Commission on Correctional Health Care Annual Conference, October 31, 2006
A Community Health Approach to Correctional Health Care, Society of Correctional Physicians, October 29, 2006
Prisoners the Unwanted and Underserved Population, Why Public Health Should Be in Jail, San Francisco General Hospital Medical Center, Medical Grand Rounds, 10/12/04
TB in Jail: A Contact Investigation Course, Legal and Administrative Responsibilities, Francis J. Curry National Tuberculosis Center, 10/7/04
Public Health and Correctional Medicine, American Public Health Association Annual Conference, 11/19/2003
Hepatitis in Corrections, CA/NV Chapter, American Correctional Health Services Association Annual Meeting, 1/17/02
Correctional Medicine, San Francisco General Hospital Medical Center, Medical Grand Rounds, 12/16/02
SuperMax Prisons, American Public Health Association Annual Conference, 11/8/01
Chronic Care Programs in Corrections, CA/NV Chapter, American Correctional Health Services Association Annual Meeting, 9/19/02
Tuberculosis in Corrections - Continuity of Care, California Tuberculosis Controllers Association Spring Conference, 5/12/98
HIV Care Incarcerated in Incarcerated Populations, UCSF Clinical Care of the AIDS Patient Conference, 12/5/97
Tuberculosis in Correctional Facilities, Pennsylvania AIDS Education and Training Center, 3/25/93
Tuberculosis Control in Jails, AIDS and Prison Conference, 10/15/93
The Interface of Public Health and Correctional Health Care, American Public Health Association Annual Meeting, 10/26/93

HIV Education for Correctional Health Care Workers, American Public Health Association Annual Meeting, 10/26/93

PUBLICATIONS

Structure and Administration of a Jail Medical Program – Part II. Correctional Health Care Report. Volume 16, No. 2, January-February 2015.

Structure and Administration of a Jail Medical Program – Part I. Correctional Health Care Report. Volume 16, No. 1, November-December 2014.

Pain Behind Bars: The Epidemiology of Pain in Older Jail Inmates in a County Jail. Journal of Palliative Medicine. 09/2014; DOI: 10.1089/jpm.2014.0160

Older jail inmates and community acute care use. Am J Public Health. 2014 Sep; 104(9):1728-33.

Correctional Health Care Must be Recognized as an Integral Part of the Public Health Sector, Sexually Transmitted Diseases, February Supplement 2009, Vol. 36, No. 2, p.S3–S4

Use of sentinel surveillance and geographic information systems to monitor trends in HIV prevalence, incidence, and related risk behavior among women undergoing syphilis screening in a jail setting. Journal of Urban Health 10/2008; 86(1):79-92.

Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail, American Journal of Public Health, 98:2182–2184, 2008

Public Health Behind Bars, Deputy Editor, Springer, 2007

Diabetes Care in the San Francisco County Jail, American Journal of Public Health, 96:1571-73, 2006

Clinical Practice in Correctional Medicine, 2nd Edition, Associate Editor, Mosby, 2006.

Tuberculosis in the Correctional Facility, Mark Lobato, MD and Joe Goldenson, MD, *Clinical Practice in Correctional Medicine, 2nd Edition,* Mosby, 2006.

Incidence of TB in inmates with latent TB infection: 5-year follow-up. American Journal of Preventive Medicine. 11/2005; 29(4):295-301.

Cancer Screening Among Jail Inmates: Frequency, Knowledge, and Willingness Am J Public Health. 2005 October; 95(10): 1781–1787

Improving tuberculosis therapy completion after jail: translation of research to practice. Health Education Research. 05/2005; 20(2):163-74.

Incidence of TB in Inmates with Latent TB Infection, 5-Year Follow-up, American Journal of Preventive Medicine, 29(4), 2005

Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings, Morbidity and Mortality Reports, (External Consultant to Centers for Disease Control), Vol. 52/No. RR-1 January 24, 2003

Randomized Controlled Trial of Interventions to Improve Follow-up for Latent Tuberculosis Infection After Release from Jail, Archives of Internal Medicine, 162:1044-1050, 2002

Jail Inmates and HIV care: provision of antiretroviral therapy and Pneumocystis carinii pneumonia prophylaxis, International Journal of STD & AIDS; 12: 380-385, 2001

Tuberculosis Prevalence in an urban jail: 1994 and 1998, International Journal of

Tuberculosis Lung Disease, 5(5):400-404, 2001

Screening for Tuberculosis in Jail and Clinic Follow-up after Release, American Journal of Public Health, 88(2):223-226, 1998

A Clinical Trial of a Financial Incentive to Go to the Tuberculosis Clinic for Isoniazid after Release from Jail, International Journal of Tuberculosis Lung Disease, 2(6):506-512,1998

AWARDS

Armond Start Award of Excellence, Society of Correctional Physicians, 2014

Award of Honor, San Francisco Board of Supervisors, 2014

Award of Honor, San Francisco Health Commission, 2014

Certificate of Appreciation, San Francisco Public Defender's Office, 2014

Certificate for Excellence in Teaching, California Department of Health Services, 2002

Employee Recognition Award, San Francisco Health Commission, July 2000

Public Managerial Excellence Award, Certificate of Merit, San Francisco, 1997

LICENSURE AND CERTIFICATION

Medical Board of California, Certificate #A32488

Fellow, Society of Correctional Physicians

Board Certified in Family Practice, 1979-1986 (Currently Board Eligible)