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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE**

FAOUR ABDALLAH FRAIHAT, *et al.*,
Plaintiffs,
v.
U.S. IMMIGRATION AND CUSTOMS
ENFORCEMENT, *et al.*,
Defendants.

Case No.: 19-cv-01546-JGB(SHKx)

**DECLARATION OF SUSI
VASSALLO, M.D.**

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**Pro Hac Vice Application Forthcoming

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DECLARATION OF SUSI VASSALLO, M.D.

I, Susi Vassallo M.D., make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct to the best of my knowledge.

Background

1. I am a board-certified emergency medicine physician and medical toxicologist. I practice as an attending physician in the emergency department of Bellevue Hospital, a large urban emergency department in New York City, and have practiced at various sites in Texas for many years. I am a Clinical Professor of Emergency Medicine at the New York University School of Medicine. I am certified as a correctional health professional by the National Commission on Correctional Health Care (NCCHC) and have evaluated correctional health care systems in six states. I have also been retained by the Department of Homeland Security to review medical care delivery at its detention facilities, and the Fifth Circuit and other courts have relied on my reports. A copy of my curriculum vitae is attached hereto.
2. COVID-19 or coronavirus disease 2019 is an unpredictably lethal virus. It causes severe pneumonia, respiratory and heart failure, systemic clotting, and death. The virus enters cells through the angiotensin-converting enzyme 2 (ACE2) receptor. These receptors are on the lungs, heart, kidneys, the fat, and other sites in the body. The immune system’s response is critical to containing the virus. However, over-response causes a multisystem inflammatory response that is life-threatening to COVID-19 patients.
3. Since the onset of the COVID-19 pandemic, I have treated about 300 COVID-19 patients in my practice at Bellevue Hospital and NYU Langone Medical Center. These patients have ranged in age from young people in their 20s to the elderly. I have also treated many COVID-19 patients who have serious Risk Factors, such as age, diabetes, respiratory issues, and hypertension, amongst others. I am very knowledgeable about not only the treatment of COVID-19 generally but also the necessary treatment and monitoring of COVID-19 patients who are medically vulnerable. In addition to my significant experience treating COVID-19 patients, I also have closely followed best practices, research, and clinical guidance regarding the treatment and monitoring of COVID-19 patients. A federal court has also

1 recently qualified me as an expert in the care and treatment of COVID-19
2 patients as well as correctional medicine.¹

3 **Nature of COVID-19**

- 4 4. COVID-19 is highly transmissible. Droplets in the air can transmit the virus
5 within at least 6 feet. Unfortunately, it is now understood that the virus is
6 spread through aerosols. This corona virus is aerosolized by fecal matter
7 through the flushing of toilets. Just talking can result in the presence of the
8 virus in indoor air for many hours. These features of COVID-19 make it
9 incredibly transmissible in the population at large. However, given the
10 congregate nature of detention facilities, the dangerousness of the virus is
11 compounded multi-fold for people in detention.
- 12 5. Persons are contagious up to 3 days before symptoms onset, and a
13 substantial number of infections result from transmission by asymptomatic
14 people. Nearly all patients (~97%) who will develop symptoms will do so
15 within 11.5 days. The symptoms may include fever, but fever is not
16 required, and present day thermometer technology is frequently inaccurate
17 and may not reflect the true body temperature.
- 18 6. The symptoms of COVID-19 present variably from fever, cough, chest pain,
19 headache, rash, loss of smell, diarrhea, vomiting, and muscle aches.
20 Although cough and fever are frequent symptoms, there are enormous
21 numbers of patients with other symptoms and no cough or fever whatsoever.
22 In one study of critically ill patients, only 88% presented with cough and
23 only 50% had a fever.² Fatigue, sore throats, body aches, ear aches, or
24 congestion frequently prove to be COVID. Abdominal pain with or without
25 fever or cough is frequently a sign of COVID. Back pain is a symptom of
26 COVID, with or without fever or cough. At Bellevue, many of our trauma
27 patients, and patients presenting with various other problems are found to
28 unexpectedly have COVID. Diarrhea is often a symptom of COVID.³ Rash
may be COVID and can be mistaken for other illnesses. Thus, screening for
cough and/or fever is alone inadequate to exclude the possibility of infection

¹ See *Gumns v. Edwards et al*, 3:20-cv-231-SDD, ECF. 57 at 22 (M.D. La. May 15, 2020).

² Covid-19 in Critically Ill Patients in the Seattle Region — Case Series, *The New England Journal of Medicine* (March 30, 2020), <https://www.nejm.org/doi/full/10.1056/NEJMoa2004500>

³ Because the ACE2 receptors are on the intestines and the lungs, diarrhea is a common presentation.

1 from COVID. Moreover, many patients are asymptomatic and are infectious
2 to others.

3 7. COVID-19 is also a highly unpredictable disease, which is one reason it is
4 so dangerous. Patients' conditions may deteriorate quickly—even after signs
5 of improvement. Thus, it is dangerous for detention facilities to assume that
6 people who present with mild symptoms will remain that way.

7 8. Amongst the greatest dangers of COVID-19 is how the virus causes micro-
8 blood clots throughout the body. These clog up the organs. In the lungs,
9 autopsy studies clearly show the thickening of the interface between the
10 alveoli (microscopic air sacs) and the capillaries. There is no oxygen
11 exchange. So, instead of a soft and pliable lung that the ventilator pushes
12 oxygen into, the lung becomes rigid, and no amount of pressure exerted into
13 the lung will make the oxygen pass across the membrane. This is why
14 patients die on ventilators because the lungs are as hard as basketballs and
15 cannot be inflated and deflated. Made rigid by micro clots, the interface
16 between the air sac trying to drop oxygen molecules into the capillaries is no
17 longer working. Sometimes there are big clots that occur in the big arteries
18 of the lungs, known as a pulmonary embolus. Sometimes there are clots in
19 the brain and strokes in very young people with COVID-19, and no other
20 risk factors are reported in the literature.

21 9. At present, there are no markers identified, nor signs or symptoms, that can
22 definitively predict clinical deterioration. Although some patients with mild
23 signs and symptoms will do well, others will deteriorate precipitously,
24 notwithstanding the mildness of symptoms. In at least one study, half of the
25 patients admitted to the intensive care unit for COVID died on the first day.
26 However, COVID patients may also present insidiously, and it is impossible
27 to predict the course of the illness, who will do well, and who will not.
28 Severe pneumonia is one of the serious consequences of COVID-19, and the
lungs become filled with fluid. I have had patients tell me, "I can't do this
anymore," as they realize they can no longer keep up the work of breathing,
and they require life-saving interventions. It is my experience treating
patients in the emergency departments of NYU Langone Health and
Bellevue Hospital Center that patients are not always aware of the degree of
hypoxia (lack of oxygen) present in their bodies. Unlike the more common
experience of holding one's breath for as long as possible and then gasping
for breath, these patients teeter on the edge of death with no gasping for
breath or feeling their need for oxygen. This has been shocking to us
working in Emergency Departments. Immediately upon arrival at the

1 hospital, life-saving measures may be required. In some cases, the patients
2 code (suffer cardiac arrest) suddenly. In other experiences, some patients
3 have adequate oxygen saturations for days and then suddenly deteriorate.

4 10. Due to the rapidity of people's deterioration, close monitoring of COVID-
5 19 patients is crucial—especially for people in detention settings.

6 Monitoring should be continuous with visualization of the patient at all times
7 by health care personnel. In detention facilities, security personnel cannot be
8 in charge of monitoring because they lack the skills and training to identify
9 deterioration. Unlike influenza, COVID patients worsen suddenly and with
10 little warning. Flu patients do not do this.⁴

11 11. Although the seriousness and trajectory of the illness cannot definitively be
12 predicted for COVID-19, there are multiple laboratory tests that can help
13 medical staff to identify how COVID-19 is impacting patients. These
14 include d-dimer, low lymphocyte counts, prolonged coagulation parameters,
15 liver and kidney function, and tests of inflammation, such as the c-reactive
16 protein, and ferritin. Inflammatory markers are abnormal, reflecting the
17 inflammatory immune response in COVID-19 patients. A high level of one
18 of these, known as Interleukin 6 (Il-6) is a target for treatment and is a
19 clinical predictor of mortality in COVID-19 patients. Plain x-rays are not as
20 sensitive as computerized tomographic (CT) scans and sometimes the plain
21 chest x-ray looks normal and the CT scan is abnormal. In order to care for
22 someone who has COVID-19, a high level of clinical judgment is crucial
23 and requires using laboratory results, the appearance of the patient,
24 particularly the work of breathing, the time since the onset of illness, and the
25 knowledge that someone who looks alright now may be acutely ill later that
26 day. This means that medical staff must not only have appropriate training
27 and qualifications to help exercise a high level of clinical judgment but also
28 that there are proper standards and guidance from ICE regarding treatment
and care of COVID-19.

12. Although advanced age and underlying illnesses or chronic medical
conditions increase the risk of serious effects of COVID, it is important to
note that relatively young and healthy patients may also require intensive
care and die. While fatalities have been highest for older patients, increasing
evidence in the US has shown the dire risk that COVID-19 poses to younger
patients. Young patients ages 20-54 years old can have serious
complications from COVID-19 including hospital admission, admission to

⁴ However, patients who test positive for the flu can have COVID-19, too, and COVID patients can likewise have influenza. One certainly does not protect from the other and they coexist.

1 an intensive care unit, invasive ventilation, or death. As of late March 2020,
2 38% of those individuals hospitalized in the US were between 20-54 years
3 old. Of those admitted to the ICU, 12% were aged 20-44 years, and 36%
4 were age 45-64 years. These statistics highlight the significant risk younger
5 people are at for serious complications due to coronavirus. In the hospital
6 where I work, there have been times with nearly 500 COVID-19 patients,
7 about half of whom are on ventilators. Many of these patients are under the
8 age of 65. The evidence and my personal experience show that all types of
9 people—healthy and unhealthy, young and old—can suffer serious
10 complications and death from COVID-19. Proper risk assessment is,
11 therefore, critical for all COVID-19 patients, and it is dangerous to assume
12 that young or healthy individuals do not require close monitoring. That
13 being said, as explained further below, correctional facilities must provide
14 heightened monitoring and treatment of COVID-19 patients who are
15 medically vulnerable because they are at a much higher risk of serious
16 complications and death from the disease.

12 **Need for increased precautions for medically vulnerable people**

13
14 13. Although COVID-19 can infect and be deadly to anyone, the virus poses a
15 particularly serious and lethal threat to older people, people with certain
16 underlying medical conditions, and pregnant people. These underlying
17 medical conditions include cardiovascular disease, high blood pressure,
18 chronic respiratory issues, diabetes, cancer, liver disease, kidney disease,
19 autoimmune disease, HIV/AIDS, history of transplantation, and severe
20 psychiatric illnesses. Increased precautions and monitoring are crucial to
21 protect these vulnerable people from infection and, if infected, from serious
22 complications and death. Below, I provide a few illustrative examples of
23 why COVID-19 is so dangerous to people with certain of these conditions.

24 14. For example, people with heart disease or cardiovascular disease are
25 especially vulnerable to COVID-19. COVID-19 decreases oxygen levels. As
26 the oxygen level drops, the heart has to beat harder and more frequently to
27 deliver adequate oxygen to the body. The heart is a pump controlled by an
28 electrical system. The ability to beat faster is limited by age-related changes
in the pump and the electrical system. In COVID, medications that treat
underlying cardiovascular conditions frequently impair the ability of the
heart to beat harder and faster to meet the demands of maintaining sufficient
blood pressure and oxygen delivery. Hypertension, congestive heart failure,
previous death of heart cells (heart attack or myocardial infarction), and
arrhythmias, such as atrial fibrillation, are examples of conditions that are
treated with medications that impair the ability of the heart to beat

1 adequately to meet the demands of the sick COVID-19 patient. Diuretics
2 used in the treatment of heart diseases deplete the amount of fluid in the
3 blood vessels. Calcium channel blockers, beta-blockers, and angiotensin
4 receptor inhibitors and blockers impede the heart function while treating the
5 underlying disease. In patients with uncontrolled hypertension, the heart
6 muscles are thickened, and this affects the heart's electrical conduction
7 system and the contractility of the pump. Additionally, the increased
8 thickness of the muscle will outgrow its oxygen supply leading to congestive
9 heart failure and heart attacks. The virus puts enormous demands on the
10 heart that often cannot be met in persons with underlying cardiovascular
11 disease. For this reason, people with heart disease are especially vulnerable
12 to COVID-19, and it is crucial that measures be taken to abate the risk of
13 infection, including increased medical monitoring.

14 15. People with kidney problems are also at a particularly high risk of serious
15 complications. To be clear, cardiovascular disease is tied directly to kidney
16 disease. It is common for the word cardiovascular to suggest only heart
17 disease. However, the "vascular" part of the word is the most important, as it
18 includes the heart, lungs, and kidneys. While the media focused heavily on
19 shortages of ventilators to supply oxygen to COVID-19 patients, there was a
20 similar urgency among health officials about the shortage of kidney support
21 machines, such as dialysis machines. The kidneys stop working due to a lack
22 of oxygen. For people with long-standing kidney problems, the kidneys may
23 already be impaired by long-standing high blood pressure causing the
24 impairment of the ability to filter. As mentioned earlier, the kidney has
25 ample ACE 2 receptors, the entry receptor for the virus. Again, as with heart
26 disease, it is absolutely crucial that people with kidney problems be
27 monitored carefully and that all available precautions be taken to prevent
28 their infection.

16. Diabetes also makes people very vulnerable to COVID-19. Diabetes is a
chronic disease that causes blood vessels to narrow and impairs the
sufficient supply of blood, the critical transport mechanism for oxygen.
Diabetes specifically affects the kidneys. Hypertension and diabetes are the
two most frequent causes of kidney failure leading to the need for dialysis. A
recent study alarmingly found that 1 out of 10 people with diabetes
hospitalized due to COVID-19 dies.⁵ Increased medical surveillance of
diabetics is therefore crucial during the pandemic.

⁵ Robert Preidt, *1 in 10 Hospitalized COVID-10 Patients with Diabetes Dies: Study*, US News (May 29, 2020), <https://www.usnews.com/news/health->

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17. Similarly, people with respiratory problems or people who suffer from underlying lung diseases are at serious risk. These conditions impair the ability of oxygen to cross from the air sacs to blood vessels. Blood clotting caused by the coronavirus further exacerbates this problem. Increased medical surveillance of people with such lung problems is therefore crucial during the pandemic.

18. People with mental illness and even dementia are also at a high risk of suffering from complications and death from COVID-19. People with mental illness or dementia may be unable to problem solve, and the ability to reason or ask for help may be impaired. This is especially true during times of illness. A person suffering from COVID-19 must be able to express himself, identify and clearly articulate symptoms, have the mental energy and interpersonal skills to ask for help and to be understood. As I have practiced emergency medicine for over 30 years in the Bellevue Hospital Emergency Department of New York City, I have encountered numerous patients who express distress, pain, or symptoms in odd or non-traditional ways. Confusion can be subtle and requires experience to recognize. In my experience, COVID patients may be uncooperative with therapeutic maneuvers due to low oxygen, metabolic derangements, fear, pain, and fever. Increased surveillance and symptom checks of people with mental illness are therefore crucial. In addition, people with mental illness who are placed in medical isolation require increased monitoring by mental health staff to ensure their mental health condition does not deteriorate.

19. I have reviewed ICE's Pandemic Response Requirements (PRR) issued on April 10, 2020 as well as the revisions to the PRR issued on June 22, 2020. In my expert opinion, the PRR and its revisions are deficient in numerous respects—in particular for its lack of guidance on care for medically vulnerable people.

20. For example, the PRR fails to prescribe specific standards or precautionary measures to protect medically vulnerable people from COVID-19 or for treating them if they ultimately become infected. As explained above, people with Risk Factors face the very real possibility of serious complications and even death if they contract COVID-19. Therefore, facilities must ensure they

[news/articles/2020-05-28/1-in-10-hospitalized-covid-19-patients-with-diabetes-dies-study.](https://www.nytimes.com/2020/05/28/health/covid-19-patients-with-diabetes-dies-study.html)

1 have proper protocols in place to protect this vulnerable population. It is
2 dangerous for ICE to presume that precautionary measures utilized for the
3 population at large are sufficient to abate the risk of harm to medically
4 vulnerable people. The revised PRR provide no specific precautionary
5 measures to help protect medically vulnerable people while in custody. For
6 example, there are no requirements that medical staff conduct increased
7 medical surveillance (e.g., symptom checks) of people who are medically
8 vulnerable. Likewise, the revised PRR does not provide special measures to
9 abate the risk of infection to medically vulnerable people, such as enhanced
10 PPE measures, increased social distancing, etc.

11 21. As for preventing COVID-19 transmission to medically vulnerable people,
12 there are a number of precautionary measures that ICE could prescribe that
13 are not reflected in the revised PRR, including but not limited to:

- 14 a. Release of all medically vulnerable persons;
- 15 b. Accelerated healthcare evaluations by a doctor or physicians assistant
16 upon intake, and upon identifying medical vulnerabilities to COVID,
17 a more comprehensive health assessment should be conducted;
- 18 c. Healthcare evaluation of currently detained people who have Risk
19 Factors and evaluation of underlying medications and how they
20 impact fighting the virus, as many medications impede the body's
21 ability to fight the virus;
- 22 d. Increased infection control measures for medically vulnerable people;
- 23 e. Increased social distancing measures for medically vulnerable people,
24 e.g., within housing areas, during programs and activities (recreation,
25 meals, law library), and medical visits;
- 26 f. Increased monitoring of medically vulnerable people, including
27 contact tracing, temperature checks, and symptom questions
28 (temperatures alone are not sufficient given that fever is only one
symptom and is not always present);
- g. Increased medical surveillance, including testing of vital signs, and
assessment of underlying conditions that make the patient vulnerable;
- h. Mandates on the use of PPE for both detainees and staff, and frequent
increased changing of PPE, as well as specification that PPE includes
use of masks;
- i. Increased cleaning of areas where medically vulnerable detainees are
present using appropriate chemical agents, and not putting detainees at
risk of inhalation or contact with such agents;
- j. Increased access to soap/sanitizer;
- k. Prohibitions on work assignments of medically vulnerable detainees,
especially for any cleaning work assignments;

- 1 l. Increased surveillance and contact tracing of staff overseeing
- 2 medically vulnerable detainees;
- 3 m. Universal and ongoing testing of medically vulnerable detainees;
- 4 n. Increased education for medically vulnerable detainees;
- 5 o. Increased training for staff overseeing medically vulnerable detainees;
- 6 p. Increased mental health treatment and monitoring for those with
- 7 mental health conditions;
- 8 q. Creating additional negative pressure rooms.⁶

9 22. The PRR likewise fails to provide necessary guidance related to the
10 treatment of COVID-19 generally, and especially what additional treatment
11 measures are necessary to abate the risk of harm to medically vulnerable
12 people. Indeed, while the PRR requires facilities to have a “Mitigation Plan”
13 for COVID-19, ICE does not mandate that mitigation plan to address proper
14 treatment of COVID-19, proper medical staffing ratios, amongst other
15 critical aspects of care.⁷

16 23. In fact, the revised PRR’s focus is almost exclusively focused on prevention
17 strategies (albeit deficiently) and altogether fails to provide crucial guidance
18 regarding the treatment and care of people with COVID, particularly for
19 medically vulnerable people. This lack of guidance means that facility staff
20 are left in the dark about what guidance to follow. This is very dangerous
21 given the novel nature of COVID-19. In my experience evaluating medical
22 care in ICE facilities, many facilities lack qualified medical staff and many
23 medical staff are acting outside their scope of practice. The lack of guidance
24 exacerbates these pre-existing problems, thereby heightening the risk that
25 medically vulnerable people will not be provided adequate treatment for
26 COVID-19.

27 24. For example, the “Management” section of the PRR is woefully deficient
28 and lacks necessary clinical guidance on the treatment of COVID-19.
Instead, the Management section primarily discusses isolation and housing
measures once there are infections. However, the PRR does not discuss other
crucial components of the management and care of COVID-19, including:
how the treatment should be provided; how frequently COVID-19 patients
should be monitored and by whom; what vitals should be checked; what
resources clinicians can access for the most updated clinical guidance; and

⁶ This is not difficult. At one hospital where I work in New York, engineers easily converted rooms to negative-pressure rooms.

⁷ See ICE Pandemic Response Requirements (June 22, 2020), at 6-7
<https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf>.

1 when hospitalization is necessary, amongst other dangerous omissions.
2 These deficiencies in ICE's guidance pose dangerous to everyone in ICE
3 custody—not just medically vulnerable people. ICE's recent revisions to the
4 PRR do not remediate these dangerous deficiencies.

5 25. For medically vulnerable detained people who are COVID-positive, the
6 facility must provide adequate and careful monitoring by qualified medical
7 staff. This includes careful monitoring of oxygen levels. As discussed above,
8 COVID-19 decreases oxygen delivery, which is especially dangerous to
9 people with certain chronic conditions. With COVID-19, the onset of
10 shortness of breath develops a median of 5-8 days after other symptoms.
11 Unfortunately, many patients are unaware that they are teetering on the edge
12 of death from low oxygen. Indeed, I have had patients present to the
13 emergency department who, when asked to walk 10 feet, have turned back
14 towards me and been visibly blue without a significant feeling of air hunger.
15 This is referred to as “silent hypoxia.” Though the feeling of breathlessness
16 (dyspnea) may ultimately occur, accompanying low oxygen levels and the
17 accompanying failure of the heart and brain occur rapidly and precipitously.

18 26. This information is crucial for facility staff to know. Staff may believe that
19 patients are doing well because of under-reporting of symptoms or lack of
20 appearance of breathlessness. This could lead to staff monitoring becoming
21 laxer just as dangers present themselves. The patient's unawareness of the
22 degree of hypoxia present and the rapidity of this progression over hours is
23 common. Thus, detention facilities cannot rely merely on people's self-
24 reporting of symptoms, including breathlessness. Rather, careful monitoring
25 of patients—including their oxygen levels—is crucial. This is especially true
26 for medically vulnerable people. Again, ICE's revisions to the PRR do not
27 fix this dangerous omission.

28 27. The PRR likewise fails to provide crucial information related to oxygen
administration. Oxygen administration is fundamental to the treatment of
hypoxia. However, the means of administration of oxygen requires a
complicated series of judgments, and therefore there is a strong need for
qualified medical staff. For example, to assess whether a COVID-19 patient
has oxygen levels that require hospitalization, medical staff must not only
know the person's oxygen saturation levels but also needs to understand the
patient's medical history, which could impact the level at which
hospitalization is necessary. For example, people with less hemoglobin
(anemia) may require hospitalization earlier than others. The same is true for
people with pre-existing lung damage, e.g., from a history of smoking.

1 28. COVID-19 patients should have their oxygen and vital signs checked
2 regularly. The pulse, respiratory rate, and oxygen saturation must be
3 performed by qualified health care providers every 4 hours throughout the
4 day and night. The results must be recorded in the medical chart. Here again,
the revisions to the PRR wholly fail to provide crucial guidance to facilities.

5 29. The PRR also neglects to provide necessary guidance and standards
6 concerning when hospitalization should occur. Defendants altogether
7 refused to address this issue in its revisions to the PRR. This is especially
8 dangerous because many healthcare staff may not understand when
9 hospitalization is necessary and hospitalization is frequently needed even
10 when a patient does not appear to be in distress. Accordingly, health care
11 personnel need guidance on when hospitalization should occur. At a
12 minimum, COVID-19 patients should be sent to the hospital immediately
13 when:

- 14 a. the oxygen saturation is $\leq 95\%$ on room air;
- 15 b. the pulse is ≥ 100 beats / minute;
- 16 c. The systolic blood pressure is ≤ 100 ;
- 17 d. There is dyspnea at rest. (shortness of breath or trouble speaking
18 whole sentences due to breathing difficulties);
- 19 e. Chest pain;
- 20 There is confusion or other signs of altered mental status;
- 21 f. The patient is pregnant;
- 22 g. Patients need additional blood testing or radiographic studies to
23 exclude a COVID-19 diagnosis because at least 15% of COVID PCR
24 tests will be negative when the patient has COVID-19. In some
25 circumstances the patient will have to go to the hospital for COVID-
26 19 testing if the test at the detention facility does not provide timely
27 results.

28 30. It is important to note that many people may require hospitalization at
earlier times, even when these parameters are not present, depending on
underlying illness and medical history. A high level of clinical judgment is
therefore crucial in assessing people's conditions and determining whether
hospitalization is warranted. One example is people with a history of lung
damage or anemia may require hospitalization earlier than when their
oxygen levels are low. Medical staff should be provided this sort of
guidance, especially because COVID-19 is a novel virus, and many medical
staff will be unprepared to respond as necessary, given their lack of
experience with this illness, and lack of training regarding management and

1 treatment of COVID-19 patients. This is why proper and comprehensive
2 guidance is so crucial and why the revised PRR is so deficient.

3 31. Upon discharge from the hospital, it is crucial that COVID patients be
4 provided necessary follow-up care. This includes an encounter with a doctor
5 or physicians assistant. If facilities lack sufficient staffing, telehealth may be
6 a good means of providing follow-up care while reducing the risk of
7 transmission from transfers to medical appointments. Here again, the revised
8 PRR is silent.

9 32. Moreover, it is critical to note that many ICE facilities are in remote
10 locations far from hospitals with adequate resources and personnel to treat
11 COVID-19. This makes hospitalization protocols all the more important,
12 because it may take a significant amount of time to transfer people from ICE
13 detention to an appropriate hospital. The amount of time taken to transfer
14 can be crucial, given how rapidly people's conditions can deteriorate.
15 Several minutes can make a difference between life or death. Facility staff
16 therefore must know, not only when hospitalization is appropriate, but also
17 whether local hospitals are full and have enough equipment (e.g.,
18 ventilators) to treat people. This issue is not adequately addressed in the
19 revised PRR. Local facilities should be mandated to ensure there are
20 sufficient numbers of ventilators, dialysis machines, and hospital beds in
21 close proximity to the facility in the event that hospitalization is necessary.

22 33. The PRR also fails to provide necessary guidance related to quarantining
23 and medical isolation. The PRR fails to make clear that conditions of
24 medical isolation and quarantine should not be the equivalent of punitive
25 solitary confinement. Solitary confinement is generally applied for punitive
26 reasons, and people are overseen by security staff. Properly administered,
27 quarantines and medical isolation are quite different. People in both units—
28 but especially medical isolation—require frequent checks by medical and
mental health staff. People also require opportunities for recreation and
material conditions that do not cause them to deteriorate mentally, including
access to TV, phones, and reading material. Further, given how rapidly
COVID-19 patients can deteriorate, people in medical isolation must be
visible to medical staff. Ideally, these should be negative pressure rooms
where the air is changed frequently throughout the day. If an airborne
infection isolation room is not available, the patient should be placed in a
single room with a closed door with the patient visible to health care
professionals. Anyone entering the room should wear personal protective
equipment and adopt universal precautions. Personal protective equipment
includes a gown, N95 respirator, goggles or face shield and gloves. Once

1 again, the revised PRR do not provide adequate guidance to ensure that
2 facilities do not utilize solitary confinement as an improper and dangerous
3 means of infection control.

4 34. The PRR also fails to provide necessary guidance concerning testing. PCR
5 testing should be universally available, and results should be available
6 within 24 hours to help mitigate risk. Detained people should be told their
7 results. For new intakes, tests could occur on arrival in conjunction with
8 tuberculosis screenings. Although ICE should provide ongoing and universal
9 testing for all people in detention, expanded testing is especially necessary
10 for medically vulnerable people. The revised PRR fails to mandate testing to
11 medically vulnerable people. In addition, the PRR fails to provide necessary
12 guidance concerning the high rate of false negatives. A significant
13 percentage of PCR tests are falsely negative; if a person tests negative but
14 has COVID-19 symptoms, they should be presumed positive and isolated
15 from others. Blood tests further elucidate the presence, absence, and
16 severity of COVID. These tests include lymphocyte counts, coagulation
17 factors and d dimer, measures of cardiac injury such as the troponin, and
18 inflammatory markers such as ferritin, c-reactive protein and erythrocyte
19 sedimentation. These tests may only be available at a hospital. Pending
20 these tests, people with COVID symptoms should be provided necessary
21 PPE and be separated from asymptomatic people who test negative, and
22 from COVID positive patients. Consistent with other failings in ICE's
23 response, the PRR revisions do not remediate these deficiencies.

24 35. The PRR and its revisions also fail to provide adequate guidance regarding
25 the use of PPE. Frequently, the PRR simply states that PPE must be worn
26 during particular circumstances, but the PRR does not specify what this
27 entails. Wherever PPE is necessary, the PRR should state with specificity
28 that masks must be worn in addition to gloves, etc. Failing to specifically
mandate the use of masks risks detention staff picking and choosing which
kinds of PPE they will wear—particularly since masks are so uncomfortable.

36. In addition, and troublingly, the PRR and its revisions do not mandate that
staff wear masks and other PPE at all times when in facilities. For example,
one of the revisions to the PRR simply requires that staff use PPE when
within 6 feet of detainees. But this fails to account for the fact that staff need
PPE when they are close to other staff members and visitors who are not
detainees, particularly because it is staff and visitors that are the primary
sources of infection at detention facilities. In this way, the revised PRR
again fails to take a necessary precautionary to protect medically vulnerable
people.

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I declare under penalty of perjury and under the laws of the United States, pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 24th day of June, in the year 2020, in the city of New York, New York.

Susi Vassallo MD

Dr. Susi Vassallo

EXHIBIT A

Exhibit A

SUSI U. VASSALLO, M.D., M.S.

Curriculum Vitae

PERSONAL DATA

Born: Austin, Texas, January 27, 1959
Citizenship: USA
Address: 6018 Mount Bonnell Cove, Austin Texas 78731
Address: 200 East 36th street, Apt.11J, New York, New York 10016
C: 646-298-4510
Susi.vassallo@nyumc.org
susivassallo@gmail.com

EDUCATION

1977 High School Diploma – McCallum High School Austin, TX
1980 Bachelor of Science Biology, Honors – University of Texas, Austin, Texas
1984 Doctor of Medicine – University of Texas, Houston, Texas

POST DOCTORAL TRAINING

Residency

1984- 1987 – Emergency Medicine, Wayne State University, Detroit Receiving Hospital, Detroit Michigan

Fellowship

1987- 1989 – Medical Toxicology Fellowship, New York University School of Medicine / Bellevue Hospital Center, New York City Regional Poison Control Center, 455 First Ave., New York New York

Masters of Science in Healthcare Management

University of Texas at Dallas School of Business and the University of Texas Southwestern Medical School
December 2016

LICENSURES AND CERTIFICATION

Licensure

1984 Texas State Medical License, #G9001
1987 New York State Medical License, #170778
2001 California State Medical License, #C50674

Board Certifications

1984 Federal Licensure Examination
1988 Diplomate, American Board of Emergency Medicine
1989 Diplomate, American Board of Medicine Toxicology
1995 Diplomate, American Board of Emergency Medicine With Subspecialty Certification in Medical Toxicology
2004 Medical Toxicology Subspecialty Recertification
2008 Diplomate Recertification, American Board of Emergency Medicine

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2018 Diplomate Recertification, American Board of Emergency Medicine
American Board of Medical Toxicology Diplomate recertification September 2018

Other Certifications

Basic Life Support
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Certified Correctional Health Professional

ACADEMIC APPOINTMENTS

May 2015-present Clinical Professor of Emergency Medicine, New York University School of Medicine / Bellevue Hospital Center, NY, NY
2014 -2018 Volunteer Clinical Faculty Emergency Medicine University of Texas Dell Medical School at Austin
September 2012 to 2014 -Clinical Associate Professor UT Southwestern Medical School Dallas, Texas
September 2009 to 2015 - Associate Professor of Emergency Medicine, NYU School of Medicine / Bellevue Hospital Center, New York, New York
1993-2009 – Clinical Assistant Professor of Emergency Medicine, NYU School of Medicine / Bellevue Hospital Center, New York, New York
Consultant NY Regional Poison Control Center 1989 to present
1987-1993- – Instructor in Clinical Medicine (Emergency Medicine), NYU School of Medicine / Bellevue Hospital Center, New York, New York

APPOINTMENTS

2016-2018 Department of Homeland Security Civil Rights and Civil Liberties Medical Expert evaluating medical care in detention facilities
1989 to Present – Attending Physician Emergency Medicine Bellevue Hospital Center and Tisch Hospital, NYU School of Medicine, NY, NY
2003 to Present – Attending Physician Emergency Medicine Veterans Administration Hospital , NY, NY

AWARDS AND HONORS

1991 – Fellow, American College of Emergency Physicians
1997 – Fellow, American College of Medical Toxicology
2003 – Fellow, New York Academy of Medicine
2014 – Fellow, American Academy of Emergency Medicine

MEMBERSHIPS, OFFICES, AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

Memberships

1989 – American Academy of Clinical Toxicology
1989 – American College of Medical Toxicology
1991 – American College of Emergency Medicine

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2003 – Society for Academic Emergency Medicine
2010 – Academy of Correctional Health Professionals

Offices

1999 – 2002 – Women’s Sports Foundation Advisory Board and Research Council
2000-2004 New York State Office of Professional Medical Conduct Consultant

Committee Assignment

2007 – 2011 American Board of Emergency Medicine, Oral Board Examiner

EDITORIAL POSITION: REVIEWER

1987 – 1989, American Academy of Clinical Toxicology Updates
1994 – Annals of Emergency Medicine
1995 – Journal of Toxicology / Clinical Toxicology
1999 – Intensive Care Medicine
2011 – American Journal of Public Health

PRINCIPAL CLINICAL AND HOSPITAL SERVICE RESPONSIBILITIES

Clinical

2015 Dell School of Medicine Volunteer Faculty.
2012 to 2017 Faculty UT Southwestern Emergency Medicine Residency at Austin, TX
1989- present: Supervise patient care, provide administrative and clinical oversight in the Bellevue Emergency Department and teach medical students and residents from all specialties.

Hospital Service

1999 to present: Office of Public Affairs, Expert in Emergency Medicine, NYU School of Medicine
1989 to present: Office of Public Relations, Expert in Emergency Medicine, Bellevue Hospital Center

MAJOR ADMINISTRATIVE RESPONSIBILITIES

1995 - 1996 – Director, Medical Toxicology Fellowship Program, NYU School of Medicine , NYC Regional Poison Control Center, NY, NY
2012- present; - Physician Advisor for Case Management Bellevue Hospital Emergency Services
Faculty Council NYU School of Medicine 2012-2016
Faculty Council Secretary NYU School of Medicine July 2014- 2016

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TEACHING EXPERIENCE

Local

- March 1988 – Bellevue Hospital and New York City Regional Poison Control Center Emergency Medicine Seminar: Non- Opioid Analgesics.
- April 1988 – Bellevue Hospital and New York City Regional Poison Control Center Emergency Medicine Seminar. Lecture: “Mushrooms.”
- May 1988 – New York Hospital / Cornell School of Medicine Flight Team. Lecture: “Helicopter Transport of the Poisoned Patient.”
- May 1988 – Bellevue Hospital and New York City Regional Poison Control Center Emergency Medicine Seminar. Lecture: “Solvent Toxicity: Has My Patient Been Exposed?”
- June 1988 – New York University Medical Center / Bellevue Hospital, Emergency Medicine Board Review Course. Lecture: “Recent Advances in Hypothermia Management.”
- March 1988 to November 1988 – New York University Medical Center / Bellevue Hospital Twenty-Two-Week Emergency Medicine Board Review Course. Lecture: “Environmental Emergencies.”
- August 1988 – New York University Medical Center, Department of Internal Medicine Conference Series. Lecture: “Hyperthermia.”
- March 1990 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy. An Intensive Review in Clinical Toxicology. Lectures on: “Calcium Channel Antagonists,” “B-blockers,” and “Digoxin.”
- October 1988 – New York University Medical Center, Postgraduate Medical School, and Bellevue Hospital, Emergency Services, Fifth Annual Five Day Emergency Medicine Board Review Course. Lecture: “Environmental Emergencies.”
- June 1990 – New York University Medical Center, Postgraduate Medical School, 10th Annual Emergency Medicine Seminar. Lectures: “Evaluation of Penetrating Trauma,” “Orthopedic Assessment and Casting,” “Airway Management,” and “Trauma Case Studies.”
- March 1991 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy, An Intensive Review in Clinical Toxicology. Lectures on: “Chemical Toxins.”
- March 1991 to November, 1991 – New York University Medical Center / Bellevue Hospital Twenty-Two-Week Emergency Medicine Board Review Course. Lecture: “Environmental Emergencies.”
- August 1991 – Metropolitan Hospital / New York Medical College, Emergency Medicine, Grand Rounds. Lecture: “Hyperthermia.”
- October 1991 – New York University Medical Center, Postgraduate Medical School, and Bellevue Hospital, Emergency Services, Sixth Annual Five-Day Emergency Medicine Board Review Course. Lecture: “Environmental Emergencies.”
- March 1992 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy. An Intensive Review in Clinical Toxicology. Lectures: “Biological Hazards” and “The Patient with an Arrhythmia.”
- June 1992 – New York University Medical Center, Postgraduate Medical School, 11th Annual Emergency Medicine Seminar. Lectures: “Resuscitation from Traumatic Arrest,” “Heat-related Disorders,” and “Orthopedic Assessment and Casting.”
- March 1992 – New York University Medical Center, Postgraduate Medical School. Course Director, One-day Seminar. Lecture: “Orthopedic Assessment for the Emergency Physician.”
- March 1993 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy, an Intensive Review in Clinical Toxicology. Lectures: “Drugs of Abuse” and “Toxic Alcohols.”

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- 1992 to 1994 – New York University Medical Center, Postgraduate Medical School Emergency Medicine Residency Program. Lecture Series: “Procedures in Emergency Medicine.”
- March 1994 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy, an Intensive Review in Clinical Toxicology. Lecture: “Hydrofluoric Acid.”
- June 1994 – New York University Medical Center, Postgraduate Medical School, 14th Annual Emergency Medicine Seminar. Lecturers: “Chest Pain and the Deformed Steering Wheel,” “Pediatric Trauma,” and “Hand Evaluation: An Intensive Minimodule.”
- June 1994 – New York University Medical Center, Bellevue Hospital, Department of Pediatrics and Emergency Services. Pediatric Emergency Medicine Lecture: “Environmental Emergencies.”
- September 28 / October 2, 1994 – Essential Topics in Emergency Medicine, presented by ACEP, Washington, D.C. Lectures: “Management of the Overdosed Patient,” “Street Drugs,” “Analgesic Drug Toxicity,” and “Envenomations.”
- March 1995 – New York City Regional Poison Control Center in conjunction with Bellevue Hospital Emergency Services and St. John’s University School of Pharmacy, an Intensive Review in Clinical Toxicology. Lecture: “Special Concerns in Pediatrics.”
- May 1995 – New York University, Bellevue Hospital Center Department of Pediatrics. Pediatric Emergency Medicine Review. Lecture: “Summertime Environmental Dangers.”
- 1995 – New York University Medical Center Postgraduate Medical School. 15th Annual Emergency Medicine Seminar. Lectures: “Critical Decisions Regarding the Diagnosis and Management of Hypo- and Hyperthermia” and “Hand Evaluation.”
- July 8, 1996 – Grand Rounds: Brooklyn Hospital Center Internal Medicine and Emergency Medicine. “Heat Illness, Pathophysiology and Treatment.”
- March 12 to 13, 1998 – New York Regional Poison Control Center, Bellevue Hospital Center. An Intensive Review in Clinical Toxicology. “Natural Toxins.”
- June 2 to 4, 1999 – NYU School of Medicine / Bellevue Hospital Department of Emergency Medicine. Contemporary Concepts in Clinical Emergency Medicine: A Literature-based Approach. How are Hypothermic Patients Best Rewarmed?
- March 9, 2000 – Lutheran Medical Center Internal Medicine Grand Rounds, New York, NY. “Sports Toxicology.”
- March 9, 2000 – An Intensive Review Course in Clinical Toxicology, New York City Poison Control Center and Bellevue Hospital Center: “Sports Toxicology” and “Snakes and Spiders.”
- April 13, 2000 – Lutheran Medical Center Internal Medicine Grand Rounds, New York, NY. Lecture: “Snakes and Arthropods.”
- June 2 to 4, 2000 – NYU School of Medicine / Bellevue Hospital Department of Emergency Medicine. Contemporary Concepts in Clinical Emergency Medicine: A Literature-based Approach, Lecture: “Fomepizole: When should it be used?”
- June 7, 2001 – Bellevue Hospital Department of Emergency Medicine 21st Annual Emergency Medicine Seminar. Contemporary Concepts in Clinical Emergency Medicine: A Literature-based Approach. Lecture: “Medical Complications of Marathons.”
- March 7 to 8, 2002 – New York Poison Control Center and Bellevue Hospital Center: An Intensive Review Course in Clinical Toxicology. “Sports Toxicology.”
- June 5, 2003 – NYU Department of Emergency Medicine 23rd Annual Emergency Medicine Seminar. Contemporary Concepts in Clinical Emergency Medicine: A Literature-based Approach. “The Pain of Prisoners: Health Care Behind Bars.”
- March 3, 2005 – American College of Emergency Physicians and the Section on Emergency Medicine. New York Academy of Medicine. Lecture: “Life in Emergency Medicine.”

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- April 1, 2005 – New York University School of Medicine. Orthopedic Injuries: Clinical Management and Controversies. “Pediatric Fracture Patterns in Child Abuse.”
- March 9 to 10, 2006 – New York City Poison Control Center and Bellevue Hospital Center. An Intensive Review Course in Clinical Toxicology. “Sports Toxicology Workshop.”
- March 30, 2006 – Office of the Chief Medical Examiner, New York City: “Trauma in the Living.”
- April 7, 2006 – NYU School of Medicine: The Orthopedic Manifestations of Child Abuse.
- August 3 to 7, 2006 – NYU School of Medicine Emergency Medicine Review Course: “Environmental Emergencies.”
- Advanced Science Seminar, NYU School of Medicine Medical Student Lecture Series August 2008: Sports Toxicology.
- March 8 to 9, 2007 – Bellevue Hospital Center / NY Regional Poison Control Center: An Intensive Review Course in Clinical Toxicology. Lectures: “Hyperthermia Syndromes” and “Sports Toxicology Workshop.”
- March 13-14 New York City Poison Control Center and Bellevue Hospital Center An intensive review Course in Clinical Toxicology. Hyperthermic Syndromes.

National Lectures

- 1994 – ACEP Scientific Assembly, Orlando, Florida. Lectures: “Antidepressant Overdose,” “Case Studies in Medical Toxicology,” and “Heat Stroke and Heat-related Disorders
- November 1988 – Johns Hopkins Medical Institutes, Department of Emergency Medicine, Baltimore, Maryland. Written Boards in Emergency Medicine, A Comprehensive Review. Lecture: “Environmental Emergencies.”
- September 1991 – San Francisco General Hospital / UCSF / Division of Emergency Medicine, Grand Rounds. Lecture: “Penetrating Trauma.”
- June 1993 – University of Texas at Houston, Department of Emergency Medicine, Houston, Texas, Grand Rounds. Lecture: “Acute Salicylate Toxicity.”
- May 15 to 19 1994 – Essential Topics in Emergency Medicine, Presented by ACEP, New Orleans, Louisiana. Lectures: “Management of the Overdosed Patient: The First Thirty Minutes,” “Street Drugs,” “Envenomations,” and “Analgesic Drug Toxicity.”
- March 20 to 24, 1995 – Society for Academic Emergency Medicine, Annual Meeting, San Antonio, Texas. Case Presentation Competition Discussant, Northeast Region.
- September 1995 – 1995 ACEP Scientific Assembly, Washington, D.C. Lectures: “Difficult Issues in Pediatric Trauma: They’re Not Just Little Adults,” “Case Studies in Medical Toxicology,” and “Snake and Arthropod Bites.”
- April 1995 – Brooke Army Medical Center Emergency Medicine Department, San Antonio, Texas. Grand Rounds. Lectures: “Iron Poisoning” and “Drugs of Abuse.”
- April 15, 1997 – University of Pennsylvania Medical Center Department of Emergency Medicine Grand Rounds: “Hypothermia.”
- April 27 – 30, 1999 – Women’s Sports Foundation Annual Summit Meeting, Washington, D.C. “Sports Toxicology.”
- April 3-5, 2000 – American College of Emergency Physicians: Emergency Medicine Connection 2000, Marriott Marquis, NY, NY 1. Pure Poison 2000 2. Case Studies in Toxicology
- Jan 14, 2000 – Uniformed Services Emergency Medicine Residency Program / Brooke Army Medical Center, Fort Sam Houston, Texas. Grand Rounds. Lecture: “Hypothermia,” “Case Studies in Toxicology,” and “New Drugs of Abuse.”
- September 17, 2000 – North American Congress of Clinical Toxicology 2000, American Academy of Clinical Toxicology. “Metformin.”

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- December 6th, 2000 – Southwestern Medical School Department of Emergency Medicine, Dallas, TX. Grand Rounds. Lecture: “Hypothermia.”
- February 7 to 11, 2004 – Rocky Mountain Winter Conference on Emergency Medicine. Grand Rounds. Lecture: Winners and Losers: The Toxicology of Performance Enhancement. Colorado Chapter, ACEP. Copper Mountain, Colorado.
- February 25, 2004 – Southwestern Medical School Department of Emergency Medicine and Dallas Poison Control Center. Winners and Losers: The Toxicology of Performance Enhancement.
- July 8, 2004 – Wayne State University School of Medicine / Department of Emergency Medicine Keynote Speaker, Detroit, Michigan. “Thermoregulatory Disorders in the Emergency Department.”
- March 15-17, 2007 – American College of Medical Toxicology 5th Annual Spring Course, Miami, FL. Lecture: “Out of Bounds: The Science and Toxicology of Testing Athletes.”
- April 13–16, 2008 – American College of Occupational and Environmental Medicine. American Occupational Health Conference, New York, NY . Invited Speaker: “The Toxicology of Testing in Sports.”
- March 7 – 8th, 2008 – Invited Panelist Fordham Law School, New York City. The Lethal Injection Debate: Law and Science. Physician Participation in Lethal Injection. Co-panelists: Gregory Curfman, M.D., Executive Editor, *New England Journal of Medicine*, Stephen Morrissey, PhD Managing Editor, *New England Journal of Medicine* and Jonathan Groner, M.D. Ohio State University. Lecture: “The Pharmacology of Lethal Injection.”
- March 3, 2009 – Fordham Law School Criminal Law Workshop, “Medical Care of Inmates,” Invited scholar by Professor Deborah Denno and Arthur A. McGivney, Professor of Law.
- October 25th, 2011: Fordham Law School: Neuroscience and the Law. Ethanol Intoxication, Withdrawal and Tolerance and the Legal Limit
- November 1, 2011 American Public Health Association: Moderator: The FDA and Public Health: Improving Scientific Integrity, Safety, and Quality of Medical Products
- November 2-5, 2011 Children’s Hospital of Philadelphia: Pediatric Emergency Medicine in Historic Philadelphia: Pediatric Toxicology
- November 27, 2012 Fordham Law School: Law and Neuroscience Speakers Series 2012. ”From the Bellevue Hospital Emergency Department; The Science of Intoxication, Tolerance and Withdrawal”.
- February 28-March 2, 2015 Austin, Texas: Annual Scientific Assembly American Academy of Emergency Medicine: “From The Emergency Department to Death Row”.
- March 19-20, 2015. Boston, MA: 8th Academic and Health Policy Conference on Correctional Health Care: “Defeating Death from Heat in Prison: A Cool Collaboration.”

International Lectures

- October 2-25 1997 – 14th Annual Scientific Conference, L’Association des Medecins d’Urgence du Quebec, Quebec City, Quebec. Lecturer. “Street Drug Intoxications,” “Cocaine Toxicity,” and “Clinical Cases in Toxicology.”
- May 22 to 25, 2002 – European Association of Poisons Centres and Clinical Toxicologists XXII International Congress, Lisbon, Portugal. “Toxicologic Effects on Thermoregulation.”
- November 18 to 20, 2004 – NYU Department of Emergency Medicine and the Department of Emergency Medicine, Tirgu Mures, Romania. Pediatric Emergency Medicine Course: “Pediatric Toxicology and Pediatric Thermoregulation.”
- February 10 to 11, 2007 – Rajavithi Hospital, Bangkok, Thailand. Advanced Training in Emergency Medicine. “The Management of Trauma.”
- June 21, 2011: San Miguel de Allende, Mexico: The Symposium on Resuscitation. Sociedad Mexicana de Medicina de Emergencia; / International Federation of Emergency Medicine: “Lipid Emulsion Infusion in Acute Overdose”

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TEACHING AWARDS RECEIVED

2002-2003– Clinical Attending Physician of the Year, NYU - Bellevue Emergency Medicine Residency Program
2005-2006 – Clinician of the Year, NYU –Bellevue Emergency Medicine Residency Program

MAJOR RESEARCH INTERESTS

Thermoregulation: Hyperthermia and Hypothermia
Drugs and Effects on Temperature
Prisoner Health: Access to appropriate health care in prison
Conditions of confinement and temperature
Drug effects on temperature regulation in prisoners

BIBLIOGRAPHY

Original Reports

1. Vassallo, SU and Delaney, KA: “Pharmacologic effects on thermoregulation: Mechanisms of drug- related heatstroke,” *Clin Toxicol* 1989; 27; 4 199-224.
2. Delaney, KA, Howland, MA, Vassallo, SU and Goldfrank LR: “Assessment of acid-base disturbances in hypothermia and their physiologic consequences,” *Ann Emerg Med* 1989;18;72-77.
3. Brown J, Hoffman RS, Aaron CK, Vassallo S: Theophylline toxicity. *Ann Emerg Med* 1989;18:425-426.
4. Vassallo, SU, Khan, A, Howland, MA: “Use of the Rumack-Matthew nomogram in cases of extended-release acetaminophen toxicity.” *Ann Intern Med* 1996;125:940.
5. Vassallo S, Delaney K, Hoffman R, Slater W, Goldfrank L: “A prospective evaluation of the electrocardiographic manifestations of hypothermia.” *Acad Emerg Med* 1999;6:1121-1126.
6. Vassallo, S, Hartstein, M, Howard, D and Stetz, J.:“Traumatic retrobulbar hemorrhage: emergency decompression by lateral canthotomy and cantholysis,” *J Emerg Med* 2002;22: 251-256.
7. Delaney, KA, Vassallo, SU, Larkin, GL, Goldfrank, LR: “Rewarming rates in urban patients with hypothermia: prediction of underlying infection,” *Acad Emerg Med* 2006;13:913-921.
8. Vassallo, SU: “Thiopental in lethal injection,” *Fordham Urban Law Journal*, Vol. 35 p. 957-964, June 2008.
9. Chen BC, Vassallo SU, Nelson LS, Hoffman: Stress Cardiomyopathy induced by Acute Cocaine Toxicity *Curr Clin Pharmacol* 2012;6:1-11.
10. Buprenorphine: Can it be Deadly in a Dose? *Emergency Medicine*. 2012 February;44(2):20-22
11. Laskowski Landry Vassallo Hoffman: Ice water submersion for rapid cooling in severe drug-induced hyperthermia. *Clinical Toxicology* 53; 181-185, 2015.
12. Fernandez D, Fara M,, Biary R, Hoffman RS, Vassallo S Balcer I, Torres D:: Clinical Reasoning: A 27 year old man with unsteady gait. *Neurology*. 2017 Sep 5:89(10).

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Reviews, Books, and Book Chapters

1. Delaney, KA, Vassallo SU, Goldfrank LR. "Hypothermia and Hyperthermia," In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, Fourth Edition*, Appleton-Lange-Crofts, Norwalk, CT 1990.
2. Vassallo SU, "Cocaine " in Tintinalli, Krome and Ruiz, (eds.) " *Emergency Medicine: A Comprehensive Study Guide, Third Edition*, McGraw-Hill, 1992.
3. Delaney, KA, Vassallo, SU, Goldfrank LR, "Thermoregulatory Principles," In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, Fifth Edition*, Appleton-Lange, Crofts, 1994.
4. Bruno, R and Vassallo, S., "Sedative Hypnotics," *Emergency Toxicology*, 2nd edition, Editor Vicellio, P. Lippincott-Raven, 1998.
5. Vassallo, S and Delaney, K, "Thermoregulatory Principles," In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Toxicologic Emergencies, 6th edition*, Appleton-Lange, Crofts, 1998.
6. Vassallo, S., "Essential Oil Toxicity," *Clinical Toxicology*, Ford, M., Delaney KD, Ling LJ, Erikson, T.(eds.) Saunders, WB, 2001.
7. Vassallo, S: "Sports Toxicology" and "Thermoregulatory Principles," " In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, 7th edition*, Appleton-Lange, Crofts, 2002.
8. Vassallo, S and Delaney, KA, "Thermoregulatory Principles," " In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, 8th Edition* McGraw-Hill, 2006.
9. Vassallo, S, "Athletic Performance Enhancers," " In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, 8th edition*, LR, McGraw-Hill, 2006.
10. Vassallo, S: Chapter 7: Environmental Emergencies. In Naderi, S., Park R (eds.) *Intensive Review for the Emergency Medicine Written Boards*. McGraw-Hill, 2009
11. **Vassallo,S: Thermoregulatory Principles. In Goldfrank LR et al *Goldfrank's Toxicologic Emergencies, 8th Edition* McGraw-Hill 2019**
12. Vassallo, S, "Athletic Performance Enhancers," " In Goldfrank LR, Flomenbaum NE, Lewin NA, et. al. (eds.) *Goldfrank's Toxicologic Emergencies, 8th edition*, LR, McGraw-Hill 2019

Educationally Relevant Publications

1. Vassallo, S., "Treatment of Methanol Intoxication." Hospital Pharmacy Hotline, Vol. 1 No 10, 1988.
2. Vassallo S., "Hypothermia," Audio Digest, Volume 7, Number 5, March 1, 1990.
3. Vassallo, S., "Clinical Challenges in Emergency Medicine: Nausea, Vomiting, Vertigo and Drug Overdose," Continuing Education Material Sponsored by Albert Einstein College of Medicine and Montefiore Medical Center. December 2001.

Abstracts

1988 AAPCC/AACT/ABMT/CAPCC Annual Meeting, Baltimore, Maryland.

Exhibit A

SUSI VASSALLO, M.D., FACEP, FACMT

REFERENCES, Page 10

- Service dichromate poisoning: Survival after hemodialysis. Vassallo, SU and Howland, MA.

1998 American Association of Poison Control Centers Meeting.

- Passion and Poison in the World's Great Opera. Platform presentation September 1998, Orlando FL.

Media

The Marshall Project: <https://www.themarshallproject.org/2017/10/11/cooking-them-to-death-the-lethal-toll-of-hot-prisons>. Cooking them to Death October 11, 2017

Houston Chronicle Federal judge orders Texas prison system to provide a/c for heat-sensitive inmates at Pack Unit by Gabrielle Banks July 19,2017 <https://www.chron.com/news/houston-texas/article/Federal-judge-orders-temporary-air-conditioning-11299434.php>

<https://feminem.org/honors/dr-susi-vassallo/> February 2018

NBC Channel 4 http://www.nbcnewyork.com/on-air/as-seen-on/Dr_-Susi-Vassallo-on-Heat-Related-Illnesses_New-York-317664951.html July 21, 2015

Texas Monthly: The Heated Battle for Cooled Texas Prisons, Annie Melton, June 2, 2014

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Exhibit A

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