STEPHEN P. BLAKE (260069)
sblake@stblaw.com
HILARY A. SOLOFF (314727)
hilary.soloff@stblaw.com
SARAH H. BRIM (323509)
sarah.brim@stblaw.com
RACHEL A. JUNE-GRABER (337148)
rachel.june-graber@stblaw.com
SIMPSON THACHER & BARTLETT LLP
2475 Hanover Street
Palo Alto, California 94304
Telephone: (650) 251-5000
Facsimile: (650) 251-5002

Attorneys for Plaintiffs Immigrant Defenders Law Center; Refugee and Immigrant Center for Education and Legal Services; South Texas Pro Bono Asylum Representation Project, a project of the American Bar Association; and The Door

[Additional counsel listed below]

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

IMMIGRANT DEFENDERS LAW CENTER; *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HOMELAND SECURITY; *et al.*,

Defendants.

Case No. 2:21-cv-00395-FMO-RAO

DECLARATION OF DR. MINAL GIRI, EXPERT WITNESS FOR PLAINTIFFS

Date: August 14, 2023
Time: 9:00 A.M.
Ctrm: 6D
Judge: Hon. Fernando M. Olguin

KAREN C. TUMLIN (234691)
karen.tumlin@justiceactioncenter.org
ESTHER H. SUNG (255962)
esther.sung@justiceactioncenter.org
JANE BENTROTT (323562)
jane.bentrott@justiceactioncenter.org
JUSTICE ACTION CENTER
P.O. Box 27280
Los Angeles, California 90027
Telephone: (323) 316-0944

Attorneys for Plaintiffs Immigrant Defenders Law Center; Refugee and Immigrant Center for Education and Legal Services; and The Door

ALVARO M. HUERTA (274787)
ahuerta@immdef.org
HANNAH K. COMSTOCK (311680)
hcomstock@immdef.org
CARSON SCOTT (337102)
cscott@immdef.org
BRYNNA BOLT (339378)_
bbolt@immdef.org
IMMIGRANT DEFENDERS
LAW CENTER
634 S. Spring Street, 10th Floor
Los Angeles, California 90014
Telephone: (213) 634-7602
Facsimile: (213) 282-3133

Attorneys for Plaintiffs Immigrant Defenders Law Center; Refugee and Immigrant Center for Education and Legal Services; and The Door

I, **DR. MINAL GIRI**, declare as follows:

I make this declaration based on professional knowledge and experience and a review of records in this case. If called as a witness, I could and would competently testify thereto under oath to the following.

A. Qualifications

1. I am a pediatrician licensed to practice medicine in Illinois. I am also nationally recognized for my work in the fields of asylum and immigration medicine and serve on the executive committee of the American Academy of Pediatrics Council on Immigrant Child and Family Health. I have experience providing forensic evaluations and/or medical treatment to individuals in Office of Refugee Resettlement ("ORR") facilities and juvenile correctional settings, as well as community outpatient and inpatient medical settings. As a result, I have extensive experience working with traumatized populations, including immigrants and asylum seekers. I have submitted affidavits and reports in investigations and immigration proceedings related to the wellbeing of immigrant children and families. I also have personally performed forensic evaluations of at least a dozen unaccompanied children, both in ORR settings and at my office, related to their immigration proceedings.

2. Additionally, in 2009, though Physicians for Human Rights, I was invited to provide research and recommendations regarding child trauma to the Department of Homeland Security ("DHS") to inform the development and amendment of regulations related to unaccompanied children, and in particular their claims for asylum. In a series of meetings and four reports, our team provided detailed, evidence-based recommendations to DHS for changes to the Code of Federal Regulations regarding appropriate procedures and rights for unaccompanied child asylum applicants.

3. I obtained my bachelor's and master's degrees in the Humanities at the University of Chicago in 1993. I obtained my medical degree from the University of Chicago Pritzker School of Medicine in 1999. I completed my pediatric internship at Children's Hospital Los Angeles from 1999 to 2000, and I completed my residency in general pediatrics at Lutheran General Children's Hospital from 2000 to 2002.

4. Since completing my residency, I have practiced pediatric medicine for over two decades. I am a Fellow of the American Academy of Pediatrics. In addition to providing primary care to pediatric patients, I also served as an assistant professor at Rush University Medical Center for ten years between 2002 and 2012. Between 2009 and 2014, I served as an Advisor in the Obesity Prevention and Care Initiative for the Illinois Chapter of the American Academy of Pediatrics.

5. I practiced general pediatrics at Melrose Park Pediatrics from 2002 to 2020, serving as medical director from 2016-2020. My clinical practice involved providing clinical care for children from birth to age 21. My practice, located on the outskirts of Cook County, was in a medically underserved area and most patients I cared for were immigrants themselves or from immigrant families. Since August 2020 I have worked for Pediatrust LLC, currently as an urgent care physician.

6. In 2019, I founded the Midwest Human Rights Consortium, a multidisciplinary, multi-institutional organization that facilitates forensic evaluations to support asylum seekers and individuals seeking various forms of immigration relief. In the process of founding the Consortium, I trained and facilitated learning for over 100 practitioners on how to conduct forensic medical evaluations on behalf of asylum seekers.

7. In 2019, I was selected to participate in the Harvard Program in Refugee Trauma and the Harvard Medical School Department of Continuing Education program, Global Mental Health: Trauma and Recovery Certificate Training Program, which provided evidence-based knowledge and skills to health and mental health

professionals, humanitarian relief workers, and policy planners caring for traumatized patients, families, and communities worldwide.

8. I have published in several peer-reviewed journals. My most recent article is entitled, "What Should Count as Best Practices of Forensic Medical and Psychological Evaluations for Children Seeking Asylum?" and was published in the American Medical Association Journal of Ethics in April 2022. This article articulated the need for trauma-informed, child-centered best practices in conducting forensic asylum evaluations for children and builds on nearly two decades of experience and prior publications in this field. In writing this article, I reviewed several scholarly articles about the asylum process in the United States, the root causes of migration, and the effects of trauma on children's brains.

9. A comprehensive list of my relevant qualifications can be found in my expert report and CV, submitted on May 9, 2022 and attached as **Appendix A**.

10. The sources that provide support for my statements below, which are also listed in my expert report, are listed in the attached **Appendix B**.

B. <u>Children Are Highly Sensitive to Trauma</u>

11. A traumatic event is defined as a dangerous, threatening, violent, or distressing experience outside the range of usual human experience that overwhelms an individual's ability to cope and frequently results in intense emotional and physical reactions, leads to feelings of helplessness and terror, and threatens serious injury or death.

12. Trauma can be further characterized as acute, chronic, or complex. Acute trauma refers to a one-time event that is limited in scope, such as a robbery or car accident (where there were no serious injuries or deaths). Chronic trauma is caused by repeated events over a prolonged period of time, such as domestic violence or sexual abuse. Complex trauma is also prolonged and repeated and involves different kinds of events or abuse, for example the experience of war, parental loss,

or forced resettlement. The literature overwhelmingly shows—and my own experience evaluating unaccompanied children has confirmed—that unaccompanied children have often experienced all of the above and have varied histories of chronic and complex trauma.

13. One of the hallmarks of trauma is that its effects do not end when the event is over; rather, the effects of the trauma linger and continue to affect the individual long after the event occurs. There are three components to trauma: (1) the event or series of events; (2) the individual experience of the event which induces an abnormally intense and prolonged stress response; and (3) the lasting physical and/or mental effects resulting from (a) the event itself, and (b) the experience of the event.

14. Children process trauma differently than adults due to neurobiological differences in brain structure that impact their perception and ability to overcome the trauma. For children, whose brains and neural circuitry are still developing, exposure to trauma can have lasting consequences on how their brains form. In the developing brain, trauma can impact and harm the physical architecture of a child's brain, preventing neurons from forming normal healthy connections. Exposure to violence, insecurity, and constant threats trigger stress hormones to be released in the brain. Over time, with constant or prolonged exposure, the brain becomes flooded and the stress hormones rewire the brain's circuitry, leading to poor, under-, or over-active communication between various parts of the brain. This can cause the brain to develop asymmetrically. The constant flood of fight/flight hormones decreases the brain's ability to down-regulate itself after a stressful event. Over time, this abnormal stress response results in excess cortisol levels in the body that can alter the body's immune processes leading to chronic disease. Difficulty with regulating fight/flight response can also lead to heightened anxiety and mood disorders such as depression.

15. Research has shown that trauma can have lasting psychological and physiological consequences that can impact the child into adulthood, even

influencing the development of chronic illness and life span. Children who have experienced chronic or complex trauma are often impacted on several levels: biologically, cognitively, socially, and psychologically. Biologically, as mentioned above, trauma can harm neural development, dysregulate the stress response, impair immune function and increase risk for chronic disease.

16. Impacts on brain development can cause cognitive issues including difficulties with learning, memory, attention, and executive function (i.e., working memory, planning, inhibition of impulses) leading to poor school performance.

17. Trauma can also lead to social problems including poor social skills and difficulty forming healthy attachments and relationships with others. It can interfere with basic functioning such as sleeping, eating, and using the toilet.

18. Psychological issues include difficulty managing stress and other emotions, and increased rates of mental health problems like anxiety, depression, personality disorders, and substance use disorders.

19. Children who have been exposed to trauma may be hesitant to reveal their past experiences, especially those at the root of their trauma. As a result, children may struggle to trust unknown adults and authority figures. Their inherent distrust of such authority figures is a survival mechanism that can serve to work against them in the court system. These reactions and hesitations are well-documented in the literature and confirmed by years of personal experience.

C. Trauma-Informed, Child-Sensitive Practices Are Critical When Working with Children Who Have Experienced Serious or Sustained Trauma

20. Trauma-informed practices can both mitigate the harmful effects of trauma and help prevent re-traumatization or ongoing trauma from occurring. There is no singular formula to conducting trauma-informed care. Rather, trauma informed care requires constant attention, self-reflection, and re-evaluation. According to the

CDC, the six general principles of trauma-informed practices are safety, trustworthiness, transparency, peer support, empowerment/voice/choice, and cultural/historical/gender issues. The principles essentially require fostering trust through open and transparent communication and promoting a sense of safety and agency. Trustworthiness and transparency means ensuring that a child is aware of their situation, understands their options, and understands the consequences of each option. Safety refers to feeling both physically and psychologically safe. Psychological safety is promoted by responding to distress with empathy. A trauma-informed approach also promotes empowerment and choice. This can be demonstrated by allowing the child the opportunity to tell their story and self-advocate **when able** and letting the child have a sense of control whenever possible, for example, something as simple as letting them choose where to sit, or what color toothbrush they want.

21. Child-centric principles require that professionals working with children in such circumstances take steps to "assure to the child who is capable of forming his or her own views the rights to express those views freely in all matters affecting the child, the view of the child being given due weight in accordance with the age and maturity of the child." The United Nations Convention on the Rights of the Child art. 12, Nov. 20, 1989, 44 U.N.T.S. 25.

22. Child-sensitive practices refer to making sure the child feels safe and secure. The circumstances, procedures, and environments that are most conducive to trauma-informed and child-sensitive practices include child-friendly spaces with toys, books, and/or art supplies. Without child-centered and trauma-informed practices in place for children who have experienced trauma, they face increased risk of harm through re-traumatization. Child-centered, trauma-informed practices allow a child the time and space required to articulate their story, one that may be harrowing and, at times, difficult to recall in a clear, linear narrative due to trauma. Without

these child-centered, trauma-informed practices in place, children are less likely to be able to advocate for themselves or contribute to their case in a meaningful way.

23. When dealing with traumatized children who have been abused, abandoned, or exposed to violence, in some cases the severity of the trauma itself may generate such severe stress as to impair the child's memory. High levels of stress not only transiently block certain brain functions, but excessive exposure to stress hormones can lead to neuronal death. In particular, the development of the region of the brain called the hippocampus, which is the center for learning and memory, can be severely impacted or stunted by high levels of circulating stress hormones. Traumatized children have been found to have asymmetric brain abnormalities and altered development of their corpus callosum, the band of tissue that allows for interhemispheric transfer of information. This in turn may impair a child's ability to fully process the trauma, preventing the brain from integrating it into memory and synthesizing a cohesive narrative version of the traumatic experience.

D. Unaccompanied Children Previously Enrolled in MPP Require Trauma-Informed, Child-Sensitive Care

24. Most if not all unaccompanied children have experienced trauma before they enter the United States, both prior to and during migration. Based on my experience and review of literature, news coverage, the filings in this case, and Defendant DFEH's "Explanation of the Decision to Terminate the Migrant Protection Protocols" (published Oct. 29, 2021), children in MPP experience even greater trauma due to their time in camps where they are exposed to constant threats of violence, hunger, and homelessness. Due to these conditions, children in MPP experience prolonged uncertainty and near-constant insecurity.

25. Unaccompanied children who present at the border <u>after their enrollment in MPP</u> have therefore faced heightened levels of trauma. They have frequently endured harsh camp conditions only to then be separated from their

primary caregivers. Regardless of the reason or mechanism of separation, the impact this has on a child's well-being is profound. Any separation from a caregiver is devastating for a child, regardless of the circumstances that child might end up in post-separation.

26. Beyond basic needs and survival, children also rely on adults to help them regulate and process their response to trauma. The presence of a caregiver can help mitigate or buffer the impact of trauma on a child. MPP-unaccompanied children no longer have that buffer. Not only are they coping with the loss of the caregiver, which is a trauma in and of itself, these children have lost that layer of protection against the hostile outside environment. They no longer have that caregiver to protect them or help them negotiate frightening, dangerous, or threatening experiences. As is well-established by research and confirmed by my personal experience, when separated from parents and family, children are especially vulnerable and may operate on a cognitive and social level less competent than predicted by their age.

27. Research demonstrates that the compounding effects of pre-migratory and detention trauma are made significantly worse by family separation. As renowned pediatrician Dr. Jack Shonkoff states, "the most potent antitoxin [to toxic or traumatic stress] is the protection provided by the reliable availability of a nurturing parent or other familiar caregiver." Based on my review of the literature and my personal experience, children rely on their caretakers to cope with challenging circumstances, and caregiver contact can decrease the adverse impact of traumatic stressors.

28. That trauma is further exacerbated by the time spent in ORR custody, adversarial courtroom proceedings, and other post-entry experiences.

29. ORR custody is a form of detention, and detention of any kind and duration is not good for a child. ORR group home settings, where the child is surrounded by strangers, can be extremely challenging for a child already coping with

trauma. In addition, being unable to reunite with a caregiver is in and of itself traumatic.

30. Adversarial courtroom proceedings can also cause trauma. Being before adults that a child does not know or trust can provoke anxiety and fear, including fear related to what the outcome of the process will be. Those feelings are magnified for a child who is away from their primary caregiver and does not understand the proceedings that are taking place.

31. Based on my personal experience and understanding of the applicable literature, because of these experiences, MPP unaccompanied children likely experience symptoms due to prolonged traumatic stress including those previously mentioned: crying, regression, loss of bladder/bowel function, sleep disturbances, irritability, changes in mood, impulsivity, and aggression.

32. Trauma-informed and child-centric principles require that professionals working with children in such circumstances, including their attorneys and legal service providers, take steps to ensure that (1) the child's basic needs are met; (2) they feel safe both physically and psychologically; (3) the child is aware of their options and the consequences of their choices; and (4) decisions being made honor the child's wishes, their safety, and their right to family integrity, liberty, development, and identity.

33. These steps are necessary because without them children will not receive the care and consideration they are due based on their inherent vulnerabilities. Unmitigated or continuing trauma has been shown to lead to potentially permanent changes in learning behavior and physiology and result in lifelong consequences of chronic illness.

E. Unlike TVPRA Proceedings, MPP Proceedings Do Not Include or Allow for Trauma-Informed, Child-Sensitive Practices

34. The TVPRA incorporates special protections for unaccompanied children, including a longer time for their attorneys and legal service providers to gather information needed for their cases. It also permits children in removal proceedings to seek asylum before USCIS, an agency that allows children to have their asylum claims considered in a non-adversarial setting. In such settings, children are questioned using child-sensitive and trauma-informed interview techniques that account for the child's age, development, language, and cultural background.

35. These protections are critical because at the most basic level, children require a stable and responsive environment with protective interactions with adults and safe and supportive physical, chemical, and built environments, which provide physical and emotional spaces that are free from toxins and fear. Children are more likely to be distressed by hostile situations and emotionally affected by unfamiliar circumstances. Child applicants also often have difficulty giving clear, consistent testimony for various reasons, including fear, embarrassment, lack of trust, and the effects of the trauma itself.

36. Children who have suffered trauma may have memory loss or distortion related to the traumatic event or may show avoidance or disassociation when asked about the event. They need to feel safe enough to tell their story. It can take months for a child to be willing to share information that is distressing or humiliating—like sexual abuse or rape—or other information that is painful to recall. Children who have experienced trauma require time—to build the trust required to tell their stories and to untangle their narratives.

37. Unlike the processes contemplated by the TVPRA, which accounts for unaccompanied children's unique needs, MPP proceedings include no such safeguards. Based on my experience and review of literature, news coverage, the

filings in this case, and Defendant DFEH's "Explanation of the Decision to Terminate the Migrant Protection Protocols" (published Oct. 29, 2021), MPP restricts access to legal counsel and does not afford children the time necessary to gather evidence to support their cases. MPP also presents great logistical barriers for attending hearings—such as requiring children to appear remotely—and limits a child's full participation in the process by not giving them an opportunity to tell their story. I have worked with children on telemedicine platforms, and know first-hand how virtual appearances create a barrier to communicating effectively and evaluating a child across screens.

38. MPP-unaccompanied children, who were previously enrolled in MPP in Mexico with a parent and later separated and appeared unaccompanied, are still processed under their ongoing or completed MPP proceedings. After being designated unaccompanied, these children are often connected with Legal Service Providers ("LSPs") like Plaintiffs for the remainder or reopening of their MPP proceedings, and possibly for removal to their home country. Depending on the child's age, development, and migration history, it is likely to take a longer time for LSPs like Plaintiffs to gain their trust or get them to reveal their story.

39. Thus, without the child-sensitive protections contemplated by the TVPRA and necessitated by the inherent vulnerabilities of child trauma survivors, MPP-unaccompanied children are severely limited in their ability to litigate their cases and without due considerations to their special needs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on June 20, 2023, at Lincolnshire, Illinois.

MINAL GIRI