

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, et al.,

Plaintiffs,

v.

WILLIAM WEILDING, et al.,

Defendants.

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Case No. 13-cv-1068

Hon. Robert M. Dow, Jr.

**PLAINTIFFS' EMERGENCY MOTION FOR
TEMPORARY APPOINTMENT OF A SPECIAL MASTER**

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Plaintiffs, a class of prisoners housed at Stateville, hereby respectfully request that this Court grant their motion and temporarily appoint a Special Master to oversee Defendants' response to the COVID-19 pandemic currently at Stateville to protect Class Members' constitutional right to be free from unreasonably dangerous conditions of confinement. In support of their request, Plaintiffs state as follows:

INTRODUCTION

COVID-19 is wreaking havoc at Stateville Correctional Center, and Defendants' current response is endangering Class Members. It is no exaggeration to describe the situation at Stateville as dire. On March 25, the IDOC announced that one prisoner had tested positive for COVID-19; as of today, there are 64 positive cases, more than 100 outstanding tests, and likely another 100 prisoners suffering from classic symptoms of the virus. At least one Class Member has already died. This Court should join the other courts across the country that have issued TROs to help contain the outbreak of COVID-19 in correctional facilities.

The local community hospital, St. Joseph Medical Center in Joliet, is overwhelmed and its medical director described the situation at Stateville as a "disaster." He urged that something needed to be done immediately, warning that Stateville's current response could cause approximately 100 Class Members to die.

Indeed, there is every reason to expect that in the coming days numerous Class Members will die. Each and every Class Member is in substantial risk in light of the outbreak of the COVID-19 pandemic at Stateville. The CDC has stressed the imperative of practicing social distancing and aggressive hygiene, things that are demonstrably impossible in Stateville's current crowded conditions. Indeed, class counsel have made continuous inquiries about what measures are being taken to protect Class Members, and the responses by defense counsel, set out below—

some extra soap for prisoners, *optional* gloves for guards, personal protective equipment (“PPE”) for some unspecified group of employees with none to Class Members—speak of half-measures taken without necessary foresight to what the coming days and weeks will entail inside the walls. Class members report that isolation of symptomatic Class Members is *not* occurring, and prisoners are left in close contact with people suffering from classic COVID-19 symptoms.¹ The medical director at St. Joseph Hospital has expressed deep concern over the inadequate isolation measures being taken in the prison.

The results speak for themselves. While the COVID-19 rate of infection in Cook County stands at .87 persons per thousand,² the rate of infection within Stateville is exponentially higher : as of April 1, 48 persons per thousand are confirmed to be infected with COVID-19, with more than 100 lab results pending. Stateville, in other words, is a powerful accelerator of COVID-19. Based on the data available yesterday, it appears that Stateville’s rate of infection is nearly forty times greater than the rate of infection in Cook County.³

¹ Plaintiffs’ counsel is working to prepare declarations in support of their motion from Class Members and their families, and will file them as a supplement to this motion.

² Compare State of Illinois, Coronavirus (COVID-19) Response, <https://coronavirus.illinois.gov/s/> (5,994 positive COVID-19 infections in Cook County) (last visited Apr. 1, 2020 at 1:50 p.m.), with United States Census Bureau, Population Estimates July 1, 2019, <https://www.census.gov/quickfacts/fact/table/cookcountyillinois/PST120218> (last visited Apr. 1, 2020).

³ As of yesterday, IDOC reported that 48 Class Members had positive test results out of a population of approximately 1,170, which equates to approximately 4.1% of its population. Ex. 1 (IDOC COVID019 Update, last visited Apr. 1, 2020); Ex. 2 (IDOC Stateville inmate population reported to be 1,173 as of June 2019). In comparison, yesterday the Chicago Tribune reported the rate of infection in Cook County, was 0.11% of the population, which makes Class Members nearly thirty-seven times greater risk of infection than residents of Cook County. See Joe Mahr and Hal Dardrick, *County maps reveal suburban spread of coronavirus infections. Some of the highest numbers are in the northern suburbs*. CHICAGO TRIBUNE (April 1, 2020), <https://www.chicagotribune.com/coronavirus/ct-coronavirus-cases-counties-cook-dupage-lake-20200401-d2dytx6zgjhldo245un7donpvu-story.html>.

Class Members who have heart conditions, diabetes, cancer, asthma, or who are older, face a particularly imminent risk of severe illness and death. Experts have calculated that individuals in those categories face a risk of mortality of between 3.6% (individuals 60 and older) and 13.2% (individuals with cardiovascular disease). In other words, Class Members who suffer from cardiovascular disease stand roughly the same chance of survival as they would playing Russian roulette. One Stateville prisoner has already died. Eight more are on ventilators, and the number of prisoners sent out to the local hospital has turned it into what one doctor called a “war zone,” taking up the hospital’s ventilators that will undoubtedly be needed by the wider Joliet community.⁴ The National Guard has been deployed to Stateville to supplement medical care, but given the dramatic rate of infections at Stateville, there is every reason to think that it, too, will be overwhelmed.

Stateville, in short, portends the nightmare scenario in which effective protective measures were not implemented, violating Class Members’ rights under the Eighth Amendment to adequate conditions of confinement and putting them at imminent risk of severe illness or death. The situation at Stateville is a matter of life and death for Class Members. This Court, which has certified the Class on precisely the question of whether their conditions are constitutionally adequate, must act.

Accordingly, Plaintiffs hereby ask this Court to grant their request for a temporary restraining order or preliminary injunction, and temporarily appoint a Special Master to monitor to assess the conditions at Stateville and Defendants’ response, and to ensure that Defendants’ actions protect the constitutional rights of Class Members. Class Members seek the appointment of an individual or individuals with correctional facility management expertise and infection

⁴ “St. Joseph Medical Center Described As a War Zone,” wjol.com (Mar. 31, 2020), *available at* <https://www.wjol.com/st-joseph-medical-center-described-as-a-war-zone/> (last visited Apr. 1, 2020).

disease or public health expertise to evaluate if Defendants' response with regard to: (1) segregating Class Members who are exhibiting symptoms of infection from healthy Class Members; (2) reducing the spread of the virus through all necessary health and sanitation recommendations; (3) instituting social distancing for living, daily activities like eating and showering; (4) providing PPE to Class Members to reduce the spread of the virus; and (5) ensuring all possible means are used to segregate any Class Members whose age or prior medical conditions puts them at increased risk of developing severe medical complications if they contract COVID-19.

FACTUAL BACKGROUND

I. The COVID-19 Outbreak Has Created a National and Global Health Emergency.

We are living in the midst of an extreme, unprecedented worldwide health emergency caused by the rapid spread of the coronavirus, COVID-19. The World Health Organization has declared COVID-19 to be a global pandemic.⁵ On March 9, 2020, Illinois Governor J.B. Pritzker issued a proclamation declaring a disaster in the State of Illinois.⁶ On March 13, President Trump declared a national emergency.⁷

⁵ Rolling updates on coronavirus disease (COVID-19), World Health Organization, <https://www.who.int/emergencies/diseases/novel-COVID-19-2019/events-as-they-happen> (last visited Mar. 29, 2020).

⁶ Gubernatorial Disaster Proclamation, *available at* <https://www2.illinois.gov/sites/gov/Documents/APPROVED%20-%20Coronavirus%20Disaster%20Proc%20WORD.pdf> (last visited Apr. 1, 2020).

⁷ Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (Mar. 13, 2020), *available at* <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/> (last visited Apr. 1, 2020).

The number of known COVID-19 infections is increasing daily. As of this morning, there were more than 820,000 reported COVID-19 cases throughout the world and more than 40,000 people had died as a result of the virus.⁸ In the United States alone, there are more than 186,000 confirmed cases and more than 3,600 deaths.⁹ In Illinois, there are more than 6,900 confirmed cases and more than 140 deaths.¹⁰ The number of COVID-19 cases in the United States is expected to grow exponentially. The Centers for Disease Control and Prevention (“CDC”) projects that without swift and effective public health interventions, more than 200 million people in the U.S. could be infected with COVID-19 over the course of the epidemic, with as many as 1.7 million deaths.¹¹

COVID-19 is a particularly contagious disease. A recent study showed that the virus can survive for up to three hours in the air, four hours on copper, up to twenty-four hours on cardboard, and up to two or three days on plastic and stainless steel.¹² Indeed, a new study of an early cluster of COVID-19 cases in Wuhan, China revealed the dangers of indirect transmission

⁸ Coronavirus disease 2019 (COVID-19) Situation Report 72, World Health Organization (Apr. 1, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200401-sitrep-72-covid-19.pdf?sfvrsn=3dd8971b_2.

⁹ Coronavirus Disease 2019 (COVID-19): Cases in U.S., Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html (last visited Apr. 1, 2020 at 2 p.m.).

¹⁰ Ill. Dep’t of Pub. Health, Coronavirus Disease 2019 (COVID-19), <http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus> (last visited Apr. 1, 2020).

¹¹ Sheri Fink, “Worst-Case Estimates for U.S. Coronavirus Deaths,” The New York Times, (Mar. 18, 2020), *available at* <https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html> (last visited Apr. 1, 2020).

¹² Marilyn Marchione, “Novel Coronavirus Can Live on Some Surfaces for Up to 3 Days,” New Tests Show, TIME (Mar. 11, 2020), *available at* <https://time.com/5801278/coronavirus-stays-on-surfaces-days-tests/> (last visited Mar. 31, 2020).

from infected people contaminating common surfaces—in the study, it was a communal mall bathroom.¹³

Controlling the spread of COVID-19 is made even more difficult because of the prominence of asymptomatic transmission—people who are contagious but who exhibit limited or no symptoms, rendering ineffective any screening tools dependent on identifying symptomatic behavior.¹⁴

There is no known vaccine or cure for COVID-19. No one is immune.

Common symptoms of COVID-19 include fever, cough, and shortness of breath.¹⁵ Other symptoms include congestion, sneezing, fatigue, or diarrhea.¹⁶ Many individuals who become infected with COVID-19 may have mild or moderate symptoms; some may experience no symptoms at all. Other patients may experience severe symptoms requiring intensive medical intervention.¹⁷ However, even with hospitalization and intensive treatment, thousands of individuals have died as a result of this infection. Regardless of the type of severity of symptoms, all infected persons are contagious and can rapidly transmit the virus from person to

¹³ Cai J, Sun W, Huang J, Gamber M, Wu J, He G. Indirect virus transmission in cluster of COVID-19 Cases, Wenzhou, China, 2020, *Emerg Infect Dis.*, 2020 Jun., *available at* https://wwwnc.cdc.gov/eid/article/26/6/20-0412_article (last visited Mar. 31, 2020).

¹⁴ Graham Lawton, “You Could Be Spreading Coronavirus Without Realizing You’ve Got It,” *New Scientist* (Mar. 24, 2020), *available at* <https://www.newscientist.com/article/2238473-you-could-be-spreading-the-coronavirus-without-realising-youve-got-it/> (last visited Mar. 31, 2020).

¹⁵ Coronavirus Disease 2019 (COVID-19), Symptoms of Coronavirus, CDC, <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html> (last visited Mar. 29, 2020).

¹⁶ Q&A on Coronaviruses (COVID-19), World Health Organization, <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses> (last visited Mar. 29, 2020).

¹⁷ *Id.*

person without proper public health interventions.¹⁸ The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.¹⁹

People over the age of fifty-five face greater chances of serious illness or death from COVID-19. In a February 29, 2020 WHO-China Joint Mission Report, the preliminary mortality rate analyses showed that individuals age 70-79 had an overall 8% mortality rate, individuals age 60-69 had a 3.6% mortality rate, and individuals age 50-59 had a 1.3% mortality rate. For individuals age 40-49, the mortality rate was 0.4%, and for individuals 40 years and younger, the mortality rate was as low as 0.2%.²⁰

People of any age who suffer from certain underlying medical conditions, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorder (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and asthma, are at elevated risk as well.²¹ The WHO-China Joint Mission Report indicates that the mortality rate for those with cardiovascular disease

¹⁸ Coronavirus Disease 2019 (COVID-19): How It Spreads, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html (last visited Mar. 29, 2020).

¹⁹ *Id.*

²⁰ Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart (Feb. 29, 2020), <https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/> (last visited Apr. 1, 2020).

²¹ Coronavirus Disease 2019 (COVID-19): People Who Need Extra Precautions, CDC, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fhigh-risk-complications.html (last visited Mar. 29, 2020).

was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.²²

For these vulnerable populations, the symptoms of COVID-19, particularly shortness of breath, can be severe, and complications can manifest at an alarming pace. Most people in higher risk categories who develop serious illness will need advanced support. This level of supportive care requires highly expensive and specialized equipment, including ventilators, that are in limited supply.²³

Increasingly, and in the United States in particular, even some younger and healthier people who contract COVID-19 may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen.²⁴ Medical providers and medical facilities are in peril of becoming completely overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 continues to spread.²⁵

The only way to prevent complications and the enormous risk to medically vulnerable people is to prevent them from becoming infected. The CDC and other public health agencies have universally prescribed social distancing—every person should remain at a distance of at least six feet from every other person—and rigorous hygiene—including regular and thorough hand washing with soap and water, the use of alcohol-based hand sanitizer, proper sneeze and

²² Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19), World Health Organization (Feb. 28, 2020), at 12, <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> (last visited Apr. 1, 2020).

²³ Ex. 3 (Decl. of Dr. Chris Beyrer) ¶ 7.

²⁴ Ex. 4 (Decl. of Dr. Jaimie Meyer) ¶ 22.

²⁵ *Id.*

cough etiquette, and frequent cleaning of all surfaces—as the only ways to meaningfully mitigate the spread of this virus.²⁶

On March 20, 2020, Illinois Governor Pritzker took the strictest measure yet to fight the virus’s spread, issuing a “stay at home” executive order for all residents effective starting March 21, 2020 through at least April 7, 2020; which was then extended to April 30, 2020.²⁷ The order directs all non-essential business and operations to cease. People are allowed to leave their homes only for essential activities. Any gathering larger than 10 people is prohibited, and people are recommended to stay at least six feet away from others. Governor Pritzker explained that his order was based on his conversations with “some of the best medical experts, epidemiologists, mathematicians, and modelers,” and all recommended a stay at home order “to avoid the loss of potentially tens of thousands of lives.”²⁸

II. Incarcerated People Are Particularly Vulnerable to Infection from COVID-19.

None of the recommended measures for mitigating the spread of COVID-19 are available for persons confined in correctional facilities and for those who must interact with them.

Correctional facilities are inherently congregate environments, where large groups of people live,

²⁶ Coronavirus Disease 2019 (COVID-19): How to Protect Yourself, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Fprevention.html (last visited Mar. 29, 2020).

²⁷ Executive Order In Response to COVID-19 (COVID-19 Executive Order No.8), https://www2.illinois.gov/HISNews/21288-Gov._Pritzker_Stay_at_Home_Order.pdf; Illinois’ Stay-at-Home Order Extended Through April, Pritzker Announces, NBCChicago (Mar. 31, 2020) <https://www.nbcchicago.com/news/local/illinois-stay-at-home-order-expected-to-be-extended-sources/2247274/> (last visited Apr. 1, 2020).

²⁸ Dan Petrella, “Gov. J.B. Pritzker issues order requiring residents to ‘stay at home’ starting Saturday,” Chicago Tribune (Mar. 20, 2020), *available at* <https://www.chicagotribune.com/coronavirus/ct-coronavirus-illinois-shelter-in-place-lockdown-order-20200320-teedakbfw5gvdgmnaxlel54hau-story.html> (last visited Apr. 1, 2020).

eat, and sleep in close contact with one another. It is impossible to achieve social distancing standards in these settings.²⁹ Therefore infectious diseases, particularly airborne diseases, such as COVID-19, are more likely to spread rapidly between individuals in correctional facilities.³⁰

The risk of contracting an infectious disease is also higher in correctional facilities like Stateville because the facilities are not sanitary environments. People share toilets, sinks, and showers, and often have limited access to soap, hand sanitizer, hot water, and other necessary hygiene items. Surfaces are infrequently washed, and cleaning supplies are in short supply.³¹ These needs are now multiplied and also compounded by the lack of (PPE), such as masks and gloves, for all staff and prisoners. This means there are more people who are susceptible to getting infected congregated together in a context in which fighting the spread of an infection is nearly impossible.

Given the history of epidemiologic outbreaks in correctional facilities, such as Tuberculosis, influenza, and MRSA, it is expected that COVID-19 will also readily spread in prisons, especially when people cannot engage in proper hygiene and adequately distance themselves from infected residents or staff.³²

The people who live in these environments—environments that defy all current public safety standards—are themselves at high risk due to the high rates of chronic health conditions, substance use, mental health issues, and aging and chronically ill populations who may be

²⁹ Ex. 3 (Meyer Decl.) ¶ 9.

³⁰ Ex. 4 (Beyrer Decl.) ¶¶ 11-16; Ex. 3 (Meyer Decl.) ¶ 9.

³¹ Ex. 4 (Beyrer Decl.) ¶ 11-16; Ex. 3 (Meyer Decl.) ¶ 11.

³² *Id.*

vulnerable to more severe illnesses, and to death, after infection from COVID-19.³³ As Dr. Craig Haney, a correctional health expert, explains, prisoners are “unusually vulnerable to stress-related and communicable diseases. Formerly incarcerated persons suffer higher rates of certain kinds of psychiatric and medical problems. Incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die).”³⁴

Additionally, correctional facilities like Stateville lack an adequate medical care infrastructure to address the spread of infectious disease, like COVID-19, and treat high-risk people in custody.³⁵ Prison health units are not equipped with sufficient emergency medical equipment, such as oxygen tanks, nasal cannulae, and oxygen face masks, to respond to an outbreak of patients with respiratory distress. For these reasons, among others, experts have warned that, “widespread community transmission of COVID-19 within a correctional institution is likely to result in a disproportionately high COVID-19 mortality rate.”³⁶ Prisons and jails rely on outside community hospitals to provide more advanced and intensive medical care, and during an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.³⁷

³³ *Id.*

³⁴ Ex. 5 (Dr. Craig Haney Decl.) ¶ 7.

³⁵ Ex. 3 (Meyer Decl.) ¶¶ 14-16.

³⁶ Dr. Brie Williams, et al., “COVID-19 in Correctional Settings: Unique Challenges and Proposed Responses,” AMEND (Mar. 23, 2020), *available at* <https://amend.us/wp-content/uploads/2020/03/COVID-in-Corrections-Challenges-and-Solutions-1.pdf> (last visited Apr. 1, 2020); *see also*

Williams, et al., “Correctional Facilities In The Shadow Of COVID-19: Unique Challenges And Proposed Solutions,” Health Affairs Blog (Mar. 26, 2020), *available at* <https://www.healthaffairs.org/doi/10.1377/hblog20200324.784502/full/> (last visited Apr. 1, 2020).

³⁷ Ex. 3 (Meyer Decl.) ¶ 16.

Prisons are not closed environments. By necessity, members of the free community, including correctional officers, social workers, attorneys, medical personnel, and many others must enter and leave the prisons on a daily basis. Staff arrive and leave each facility three times a day in large numbers, and there is little to no ability to adequately screen staff for new, asymptomatic infection. When the COVID-19 virus occurs and spreads within a prison, all persons, staff and prisoners alike, are at heightened risk of contracting the virus and, in turn, spreading the virus to others with whom they come in contact in their own homes and neighborhoods.

At the Governor's March 29, 2020, daily briefing on the coronavirus situation, IDPH Director Dr. Ngozi Ezike acknowledged the present danger that when the infection enters prisons, the congregate nature of these facilities, with staff coming and going from the community each day in large numbers, will "increase the rate of infection and its fast spread through these facilities."³⁸

The next day, following the death of a COVID-19 patient at Stateville, Dr. Ezike again acknowledged the heightened risk posed by correctional settings and the inability to conform them to public health standards:

Congregate settings such as Stateville, any other correctional center, pose unique challenges in stopping the spread of disease and protecting the health of individuals who live and work there. Those who are incarcerated obviously live and work and eat and study and recreate all within that same environment, heightening the potential for COVID-19 to spread really quickly once it's introduced.

The options for isolation of COVID-19 cases are limited in this focused setting and it becomes very difficult depending on the size of the facility and the population that's already in the facility. Ideally, all cases should be isolated

³⁸ March 29: Governor JB Pritzker Delivers Daily Coronavirus Briefing, NBC, *available at* <https://www.nbcchicago.com/top-videos-home/march-29-governor-jb-pritzker-delivers-daily-coronavirus-briefing/2246851/> (last visited Apr. 1, 2020).

individually and close contact should be quarantined individually. I know our partners at the Department of Corrections are working innovatively to try to create the best situations for these, for these facilities. But some facilities and correctional centers do not have enough individual cells, and so we are considering isolating multiple laboratory confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group.³⁹

These comments confirm that Defendants themselves recognize the dire situation that the inherently congregate setting of correctional facilities like Stateville pose to Class Members.

III. IDOC's Medical Care Program is Gravely Under-Resourced and Under-Functioning, and Is Not Capable of Managing COVID-19.

Even before COVID-19, IDOC's medical care program was ill-equipped to meet the medical needs of prisoners in its care. For more than a decade, IDOC has been mired in litigation over its consistent failure to maintain a minimally adequate system. *See Lippert v. Jeffreys*, No. 10 cv 4603 (N.D. Ill.). In 2014 and again 2018, the *Lippert* court appointed teams of independent experts to conduct exhaustive reviews of IDOC's medical system, both of which exposed a system in dire need of reform. In October 2018, the team of experts issued a 1200-page report, reaching the following the conclusions:

- a) The clinical care provided within IDOC was “extremely poor” and “resulted in preventable morbidity and mortality”;
- b) IDOC lacked an adequate infections disease control program;
- c) IDOC's Infectious Disease Coordinator position was vacant and had been vacant since at least 2014;
- d) Systemic sanitation problems existed in at multiple IDOC facilities;
- e) IDOC's medical staff vacancy rates were “very high” and staffing was a “critical problem” throughout IDOC;

³⁹ March 30: Governor JB Pritzker Delivers Daily Coronavirus Briefing, NBC, *available at* <https://www.nbcchicago.com/top-videos-home/march-30-governor-jb-pritzker-delivers-daily-coronavirus-briefing/2247385/> (last visited Apr. 1, 2020).

- f) Physician staffing at IDOC was “very poor,” with “persistent and ongoing vacancies” in site medical director positions, high rates of turnover, and an overreliance on “traveling” medical directors who go from site to site;
- g) Physicians who worked at IDOC were improperly credentialed, which was “a major factor in preventable morbidity and mortality” and “significantly increase[ed] the risk of harm to patients within IDOC.”⁴⁰

Less than one year ago, IDOC agreed to a consent decree, which was approved and entered by the Court in May 2019, to begin needed reforms. *See Lippert v. Jeffreys*, No. 10 cv 4603 (N.D. Ill.), Dkt. 1238 (consent decree). The consent decree called for the appointment of an independent monitor and a near complete overhaul of IDOC’s medical system.

In the nine months since the *Lippert* consent decree was entered, IDOC has taken preliminary steps to comply, but circumstances within the facilities remain largely unchanged. IDOC is still only in early stages of developing a compliance plan. There has been no meaningful on the ground change yet; facilities are still critically under-staffed and under-resourced. IDOC is simply unable to adequately meet the serious medical needs of IDOC’s population even under non-pandemic circumstances.

Even before the COVID-19 outbreak, in November 2019, the *Lippert* court monitor warned that the prevalence of elderly and infirm individuals in IDOC was straining the system.⁴¹ Regarding this population, the monitor noted: “It is the position of the monitor that in the short term additional IDOC resources must be directed to properly house and care for this population but in the near future the IDOC must take the lead to create a pathway to discharge those men and women whose mental and medical conditions make them no longer a risk to society to appropriate settings in the community.”⁴²

⁴⁰ Ex. 6 (*Lippert* Expert Report, October 2018) at 9-10, 21-31, 84-91.

⁴¹ Ex. 7 (*Lippert* Court Monitor Report, November 24, 2019) at 9-10.

⁴² *Id.*

Since the outbreak of COVID-19, IDOC administrators have issued memos to prisoners notifying them that their medical resources were “stretched thin” and that they needed to focus “on [their] most vulnerable patients at this time.”⁴³

IV. Stateville Is In Crisis.

The IDOC announced the first confirmed case of COVID-19 at Stateville on Wednesday, March 25, 2020. By March 29, at least one Class Member had died. Today, just seven days later, there are 64 confirmed cases of the virus at Stateville, with 19 Class Members hospitalized and more than 100 tests still outstanding (with a 45 percent positive rate).⁴⁴ Just yesterday, Brigadier General Richard Neely told the public during the Governor’s briefing that the current plan for Stateville is house men in 8-person tents within the gymnasium of the facility, after permitting these same Class Members to serve as disease vectors for several days, exposing several other Class Members to the virus.⁴⁵

This situation is creating an unprecedented health crisis for Class Members, correctional officers who are supposed to ensure their safety, and the medical community who treat Class Members. Defendants reported on Friday, March 27, 2020, that any Class Members who tested positive for COVID-19 were being taken to St. Joseph Hospital for treatment.⁴⁶ But days later, Dr. John Walsh, the medical director at St. Joseph Hospital reported that the hospital was

⁴³ Ex. 8 (IDOC Memorandum, COVID-19 Response).

⁴⁴ IDOC COVID-19 Response, <https://www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx> (last visited Apr. 1, 2020 at 3:20 p.m.); *see also* Gov. J.B. Pritzker Press Briefing, *available at* <https://news.wttw.com/chicago-tonight-live-stream-special-report> (last visited Apr. 1, 2020 at 3:20 p.m.).

⁴⁵ *Id.*

⁴⁶ Ex. 9 (Email Corresp. Between Counsel) at 6.

“overwhelmed” by Class Members suffering from the effects of COVID-19 and that staff were “maxed out.”⁴⁷ Dr. Walsh explained that “something has to be done at Stateville. You will have a huge epidemic This could end up with up to 100 inmates dying if this is out of control, and they are not isolated well at this point.”⁴⁸ And with 19 Class Members requiring hospitalization, Dr. Walsh’s warning is quickly becoming the reality.

V. Defendants’ Response to the COVID-19 Outbreak at Stateville Is Inadequate.

Defendants were aware of the potential danger and risk COVID-19 posed to Class Members even prior to any positive COVID-19 test results by staff or Class Members.⁴⁹

For starters, On March 17, 2020, advocates sent a letter to Governor Pritzker urging him to order IDOC to release individuals in a way that is consistent with public safety.⁵⁰ The letter outlined a number of specific actions Governor Pritzker should take to protect the vulnerable individuals in IDOC custody, as well as the staff who work there, including: (1) immediately ordering the release of individuals whose release dates are within 120 days; (2) release all individuals in custody awaiting parole revocation hearings; (3) prioritize release for any individuals whose release plans are pending host site approval; (4) order IDOC to stop taking people into custody for parole violations unless they present a clear and present danger of imminent physical harm, and rescind all parole warrants; (5) release individuals with viable clemency petitions; (6) take all actions necessary to maximize good time credits; (7) evaluate

⁴⁷ Chuck Goudie, “Illinois prisoners sick with COVID-19 ‘overwhelm’ Joliet hospital,” ABC (Mar. 30, 2020), *available at* <https://abc7chicago.com/coronavirus-illinois-chicago-cases/6064085/> (last visited Mar. 31, 2020).

⁴⁸ *Id.*

⁴⁹ *See generally*, Ex. 8 (Email Corresp. Between Counsel).

⁵⁰ Ex. 10 (Mar. 17, 2020 Letter).

individuals who are pregnant, postpartum, or living with their infants in IDOC programs; (8) evaluate individuals with HCU living assignments and chronic care needs for consideration of early release; (9) take steps to limit intake into IDOC facilities; and (10) ensure that the IDOC has the resources necessary to combat a possible COVID-19 outbreak in one or more IDOC facilities.⁵¹

In addition, in this matter, Class Counsel has been in communication with Defendants in the weeks leading up to this motion in an effort to ensure that all appropriate and necessary measures were being taken to reduce the risk of the virus spreading at Stateville.

A. Access to Soap, Adequate Cleaning Supplies, Laundry and Towels

Class Counsel initially requested information related to the health and safety conditions for Class Members on March 18, 2020.⁵² On March 20, 2020, Defendants reported the following regarding Class Members' access to hygiene items:⁵³

- **Access to Soap/Cleaning Supplies:** [REDACTED]
[REDACTED]
[REDACTED]
- **Soap:** [REDACTED]
[REDACTED]
[REDACTED]
- **Clean Towels:** [REDACTED]
[REDACTED]

⁵¹ *Id.*

⁵² Ex. 11 (Earlier Emails Between Counsel) at 1.

⁵³ Ex. 8 (Email Corresp. Between Counsel) at 10-11.

At that time, there were no known cases of COVID-19 at the facility—but the potential of pandemic outbreak within prisons and jails had been widely predicted.⁵⁴

The following week, on March 26, 2020, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

On Monday of this week, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Class Counsel has not been able to confer with Class Members to confirm whether or not the increased access to free soap, cleaning supplies, laundry detergent, laundry services and showers has been effectuated given the lack of ability to conduct legal calls

⁵⁴ See, e.g., Peter Wagner, “Prisons and jails are vulnerable to COVID-19 outbreaks,” The Verge (Mar. 6, 2020), available at <https://www.prisonpolicy.org/blog/2020/03/06/pandemic/> (last visited Mar. 31, 2020).

⁵⁵ Ex. 8 (Email Corresp. Between Counsel) at 3.

⁵⁶ *Id.*

at this time or visit the facility while it is a state of lock down in response to the COVID-19 pandemic.

B. Inability to Social Distance or Effectively Quarantine Infected Class Members.

Notably, however, none of the measures relayed by IDOC counsel involved taking measures to implement effective social distancing. That is because given Stateville's current population, such measures are impossible. Due to the nature of Stateville and the size of its current population of 1,173 inmates,⁵⁷ it is not possible for Defendants to put into place its IDOC's pandemic response to sufficiently protect Class Members from contracting COVID-19. While all correctional facilities face certain unique challenges, given the age of Stateville, the conditions of its buildings, and the size of its inmate population, it is nearly impossible for Defendants to implement IDOC's [REDACTED]

[REDACTED] is particularly the case given that most Class Members reside in one of the four housing units in the Quarter House, which was built in 1930, and already has identified structural safety issues. *See* Dckt. 224-1 at 14-21.

At the time of this filing, the magnitude of the outbreak of COVID-19 at Stateville is rapidly increasing. On March 31, the Illinois Department of Health reported that there were twelve Class Members hospitalized with the virus, another seventy-seven reported with fevers and eleven staff members who were isolated.⁵⁹ That number is likely is no longer accurate as at

⁵⁷ Stateville Correctional Center population was reported to be 1,173 inmates as of June 2019, with an additional 1,302 at the Northern Reception Center, *available at* <https://www2.illinois.gov/idoc/facilities/Pages/statevillecorrectionalcenter.aspx> (last visited Apr. 1, 2020).

⁵⁸ Ex. 12 (IDOC Pandemic Plan) at 68; *id.* at Attachment 1.

⁵⁹ Ex. 13 (Illinois Dept. of Public Health COVID-19 Update, March 31, 2020)

least seventeen Class Members were reported to be hospitalized at St. Joseph's yesterday, nine of whom are receiving respiratory support.⁶⁰ And, by Tuesday afternoon, a local Joliet newspaper reported, The Patch, reported that the Mayor of Joliet, Bob O'Dekirk, claimed that the number of Class Members at St. Joseph's had been reduced to fourteen with two Class Members being returned to Stateville and two other Class Members being transferred to other area hospitals.⁶¹

Class Members include many who are elderly, medically compromised or immune-suppressed. These Class Members are recognized by IDOC to be of particular risk if they contract COVID-19.⁶²



RELIEF SOUGHT

Class Members seek an emergency, temporary appointment of a Special Master agreeable to both parties to assess the IDOC's response to the COVID-19 outbreak at Stateville, and to ensure that the health, safety and lives of Class Members is being protected. Class Members seek an individual or individuals with expertise in correctional facility management as well as

⁶⁰ Chuck Goudie, "Illinois prisoners sick with COVID-19 'overwhelm' Joliet hospital," ABC (Mar. 30, 2020), *available at* <https://abc7chicago.com/coronavirus-illinois-chicago-cases/6064085/> (last visited Mar. 31, 2020).

⁶¹ John Ferak, "National Guard To Help With Stateville Coronavirus Outbreak," THE PATCH, (updated Mar. 31, 2020), *available at* <https://patch.com/illinois/joliet/amp/28666889/16-stateville-coronavirus-patients-st-joes-mayor> (last visited Apr. 1, 2020).

⁶² Ex. 12 (Pandemic Plan) at 25.

infectious disease and/or public health who will be charged with, among other responsibilities the Court deems appropriate: (1) segregating Class Members who are exhibiting symptoms of infection from healthy Class Members; (2) reducing the spread of the virus through all necessary health and sanitation recommendations; (3) instituting social distancing for living, daily activities like eating and showering; (4) providing PPE to Class Members to reduce the spread of the virus; and (5) ensuring all possible means are used to segregate any Class Members whose age or prior medical conditions puts them at increased risk of developing severe medical complications if they contract COVID-19.

LEGAL STANDARDS

On a motion for a preliminary injunction or temporary restraining order, the plaintiff “must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *Mich. v. U.S. Army Corps of Eng’rs*, 667 F.3d 765, 769 (7th Cir. 2011).

“For purposes of a TRO or preliminary injunction, a plaintiff need only establish a ‘trivial chance of succeeding on the merits.’” *Frullati Franchise Sys., Inc. v. Dana Areece & Co.*, 2001 WL 743427, at *2 (N.D. Ill. June 28, 2001) (quoting *Green River Bottling Co. v. Green River Corp.*, 997 F.2d 359, 361 (7th Cir. 1993); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046 (7th Cir. 2017) (a party moving for a preliminary injunction must “only show that his chances to succeed on his claims are better than negligible” (internal quotation marks omitted)). “The more likely a plaintiff’s success on the merits, the less the balance of harms needs to favor its side to justify relief, while a greater showing that the balance of harms favors the plaintiff may offset a lower probability of success on the [merits].” *Aon Risk*

Servs. Cos. v. Alliant Ins. Servs., Inc., 415 F. Supp. 3d 843, 847 (N.D. Ill. 2019); *Hoosier Energy Rural Elec. Co-op., Inc. v. John Hancock Life Ins. Co.*, 582 F.3d 721, 725 (7th Cir. 2009) (“How strong a claim on the merits is enough depends on the balance of harms: the more net harm an injunction can prevent, the weaker the plaintiff’s claim on the merits can be while still supporting some preliminary relief.”).

Courts have broad power to fashion equitable remedies to address constitutional violations in prisons. *Hutto v. Finney*, 437 U.S. 678, 687 n.9 (1978). And although courts must “be sensitive to the State’s interest[s]” in imprisonment, courts “must not shrink from their obligation to enforce the constitutional rights of all persons, including prisoners [and] . . . may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration.” *Brown v. Plata*, 563 U.S. 493, 511 (2011).

Courts throughout the Country are recognizing that this crisis cries out for even greater relief than the kind sought by Plaintiffs here. *See, e.g., Thaker, et al. v. Doll, et al.*, No. 20 C 0480, Dkt. 47 (M.D. Pa. Mar. 31, 2020); *Basank v. Decker*, No. 20-cv-2518, 2020 WL 1481503 at *4-5 (S.D.N.Y. March 26, 2020); *Castillo v. Barr*, No. 20-cv-00605, 2020 WL 1502864, at *6 (C.D. Cal. Mar. 27, 2020); *United States v. Doshi*, No. 13-cr-20349, 2020 WL 1527186, at *1 (E.D. Mich. Mar. 31, 2020); *Xochihua-Jaimes v. Barr*, No. 18-cv-71460, 2020 WL 1429877, at *1 (9th Cir. Mar. 24, 2020). Although in another case, prisoners in IDOC have sought a temporary restraining order, *see Money v. Pritzker*, No. 20 C 2093 (N.D. Ill.), here the Class Members seek only the appointment of a Special Master to ensure that Defendants do not continue to violate their constitutional rights, leaving to suffer substantial illness and death. This Court should grant Plaintiffs’ motion.

ARGUMENT

I. **Class Members Can Demonstrate A Reasonable Likelihood of Success On the Merits.**

As described in more detail below, Class Members are reasonable likely to succeed on the merits by demonstrating that the current conditions of their confinement pose a dire risk to their health and safety and thus violate the Eighth Amendment. As such they easily surpass the showing required for a TRO—that their chance of success on the merits is greater than “trivial” or “negligible.” *Frullati Franchise Sys.*, 2001 WL 743427, at *2; *Whitaker*, 858 F.3d at 104.

The Supreme Court has long held that when state officials “strip[prisoners] of virtually every means of self-protection and foreclose[] their access to outside aid, [they] are not free to let the state of nature take its courts.” *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). State officials have a responsibility under the Eighth Amendment to “take reasonable measures to guarantee the safety of the inmates” *Id.* at 832. The Seventh Circuit has held that the Eighth Amendment is violated by the conditions of a prisoner’s confinement when “(1) there is a deprivation that is, from an objective standpoint, sufficiently serious that it results in the denial of the minimal civilized measure of life’s necessities, and (2) where prison officials are deliberately indifferent to this state of affairs.” *Gray v. Hardy*, 826 F.3d 1000, 1005 (7th Cir. 2016).

In *Helling v. McKinney*, 509 U.S. 25 (1993), the Supreme Court held that the Eighth Amendment forbids deliberate indifference to conditions that “pose an unreasonable risk of serious damage to . . . future health.” *Id.* at 35. The Supreme Court in *Helling* addressed exposure to secondhand smoke, but it recognized that “deliberate indifference to the exposure of inmates to a serious, communicable disease” would similarly violate the Eighth Amendment, even if a prisoner *currently* shows no serious symptoms. *Id.* at 33. The Seventh Circuit has similarly recognized that the Eighth Amendment protects prisoners from known exposure to

serious diseases, holding that in such a circumstance, “[t]he prison must be allowed to choose between removing the prisoner from the unhealthy environment and protecting him from its consequences . . . provided, of course, that the protection is efficacious.” *Powers v. Snyder*, 484 F.3d 929, 931 (7th Cir. 2007); *see also McDonald v. Hardy*, 821 F.3d 882, 889 (7th Cir. 2016) (explaining that the Eighth Amendment does not excuse deliberate indifference simply because harms “have not yet reached the point of causing acute or life-threatening injuries”).

Like the secondhand smoke in *Helling*, COVID-19 lurks within the walls at Stateville, putting all Class Members at risk. Even now, with limited information, Class Members can demonstrate that their risk of contracting COVID-19 is magnitudes greater because they reside at Stateville. As of the date of this filing, the rate of infection for Class Members appears to be **at least forty times greater** than the rate of infection within Cook County, which itself has the highest rate of infection of any county in Illinois.⁶³ As of April 1, Cook County was reported to have 3,087 positive tests with a population of 2.7 million, which equates to 0.11% of the population with a positive test result. Put another way, in Cook County 0.87 persons per 1,000 have tested positive for COVID-19. At Stateville, as of yesterday, 48 Class Members had positive test results out of a population of approximately 1,100, which equates to approximately 4.4% of the population. Or, 48 persons per 1,100 are confirmed cases.⁶⁴ Simply put, Class Members can demonstrate that their risk of contracting COVID-19 at Stateville magnitudes

⁶³ See Joe Mahr and Hal Dardrick, *County maps reveal suburban spread of coronavirus infections. Some of the highest numbers are in the northern suburbs*, CHICAGO TRIBUNE (April 1, 2020), <https://www.chicagotribune.com/coronavirus/ct-coronavirus-cases-counties-cook-dupage-lake-20200401-d2dytx6zgihldo245un7donpvu-story.html>.

⁶⁴ Compare State of Illinois, Coronavirus (COVID-19) Response, <https://coronavirus.illinois.gov/s/> (5,994 positive COVID-19 infections in Cook County) (last visited Apr. 1, 2020 at 1:50 p.m.), with United States Census Bureau, Population Estimates July 1, 2019, <https://www.census.gov/quickfacts/fact/table/cookcountyillinois/PST120218> (last visited Apr. 1, 2020).

above what the rate or risk of infection is the most infected county in the state by virtue of being housed at Stateville.

Defendants knew that infectious diseases such as COVID-19 would spread at a greater rate at Stateville. Despite this knowledge, Defendants failed to take even the most basic steps that the IDOC had recognized were necessary to prevent a massive outbreak of the disease within the prison. Ex. 12 (IDOC Pandemic Plan). Specifically, when presented with a suspected or confirmed case, the IDOC's [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Rather than perform immediate quarantining and isolation, Class Members who report classic COVID-19 symptoms have been taken out of their cells to other areas of the prison where they are in close proximity with other prisoners who are complaining of sickness, and returned back to their cell—all the while being escorted by correctional staff who until just recently were not required to wear any PPE. These practices make the current rate of infection at Stateville—which appears to be increase by double per day—unsurprising. Stateville's current plan—to house certain symptomatic prisoners in 8-person bunks in the small gymnasium on grounds at Stateville—seems equally concerning, and strikes Plaintiffs' counsel as a potential death sentence for prisoners who may suffer some symptoms but do not actually have COVID-19.

Defendants' ability to perform adequate quarantining and isolation is of paramount importance, given the conditions in which Class Members live. As described above, Stateville is

an inherently congregate setting. Class Members sleep, eat, bathe, go to the bathroom, exercise, and perform every other daily life function in close proximity with one another. They have no meaningful ability to perform the imperative social distancing that the President, the Governor, and the CDC have all recognized is critical to slowing the spread of the disease.

Public health officials around the nation have recognized the uniquely dangerous situation that correctional facilities and other cluster environments create for the spread of COVID-19. *See, e.g.,* Ex.12 (CDC Recommendations for Correctional/Detention Facilities); *see also. See, e.g., United States v. Doshi*, No. 13-CR-20349, 2020 WL 1527186, at *2 (E.D. Mich. Mar. 31, 2020) (“the high density of prison populations makes federal prisons ideal transmission grounds for the virus”) (citing Kimberly Kindy, *An Explosion of Coronavirus Cases Cripples a Federal Prison in Louisiana*, The Washington Post (March 29, 2020)), *available at* https://www.washingtonpost.com/national/an-explosion-of-coronavirus-cases-cripples-a-federal-prison-in-louisiana/2020/03/29/75a465c0-71d5-11ea-85cb-8670579b863d_story.html (last visited Apr. 1, 2020); *Josefina Coronel, et al., Petitioners-Plaintiffs, v. Thomas Decker, et al., Respondents-Defendants. Additional Party Names: Jose Madrid, Jose Otero, Juan Morocho Sumba, Miguel Miranda*, No. 20-CV-2472 (AJN), 2020 WL 1487274, at *3 (S.D.N.Y. Mar. 27, 2020) (“[B]eing in immigration detention places Petitioners at significantly higher risk of contracting COVID-19. Individuals in carceral settings are at a ‘significantly higher’ risk of spreading infectious diseases. It is not possible to isolate immigration detainees from the outside world (including from staff and vendors who may have been exposed to COVID-19), nor is it possible to isolate them from one another. As a result, jails will struggle to contain any eventual outbreak of COVID-19.”) (citation to record and affidavits omitted).

The inability to perform any meaningful social distancing from both prisoners and staff is troubling, even in facilities where there is no outbreak of the disease; in a prison like Stateville where there are more than 64 cases, it is deadly. And Defendants have compounded this problem by withholding both information and hygiene items, where even today the IDOC has offered no information to prisoners about their ability to access additional hygiene supplies.

In other words, at Stateville, Defendants have been and still are two steps behind the disease. Class Members can simply not afford to take that risk. Their lives are quite literally on the line. Courts have granted TROs to inmates for similar or even much less risk of harm, and this Court should do so here. *See, e.g., Kirsch v. Racine Cty. Sheriff*, 2008 WL 4780614, at *1 (E.D. Wis. Oct. 30, 2008) (granting TRO to inmate being transferred to jail that would not provide methadone for pain treatment where the “withholding of his methadone will cause terrible physical pain, withdrawal symptoms, and serious risk of cardiac arrhythmia and heart attack”). COVID-19 is rapidly spreading at Stateville, with zero cases reported as of March 24, 2020, 28 cases as of two days and now at least 48 confirmed Class Member cases, with more than 100 more suspected—a rate of infection nearly 40 times greater than Cook County, the most infected county in Illinois. Ex. 1. Defendants have left Class Members to sit in their cells and wait for this disease to rip through their prisons, leaving death and severe illness in its wake. The Constitution demands better. This Court should accordingly appoint a Special Master to ensure that the constitutional rights of Class Members are being protected during this pandemic.

II. Class Members Will Suffer Irreparable Injury, Including Death.

Class Members are at great risk of contracting COVID-19 because they reside at Stateville. One Class Member has already died and several others are currently in critical condition receiving respiratory support at St. Joseph’s. Another ten to twelve Class Members are

hospitalized. And, there is imminent risk that the tsunami of Class Members with severe medical complications will flood the local hospitals as many Class Members are at increased risk of complications from COVID-19 due to having heart conditions, diabetes, immuno-compromised status or simply their advanced age, which puts them at an increased likelihood of developing complications. As set forth above, individuals with these types of medical conditions are at increased risk of complications and death. The WHO-China Joint Mission Report indicates that the mortality rate for those with cardiovascular disease was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.⁶⁵

It is not an exaggeration, but simply a fact, that Class Members face the harm of suffering death at a staggering rate, and one that could be substantially decreased with an appropriate response to the outbreak. These life-and-death stakes are sufficient to establish a likelihood of irreparable harm in support of injunctive relief. *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of U.S., Inc.*, 549 F.3d 1079, 1090 (7th Cir. 2008) (irreparable harm means that the plaintiff cannot be “prevented or fully rectified by the final judgment after trial”); *Orr v. Shicker*, ___ F.3d ___, 2020 WL 1329659, at *9 (7th Cir. Mar. 23, 2020) (irreparable harm is that which “cannot be repaired and for which money compensation is inadequate” (internal quotation marks omitted)). “The existence of a continuing constitutional violation constitutes proof of an irreparable harm.” *Preston v. Thompson*, 589 F.2d 300, 303 n.3 (7th Cir. 1978) (affirming grant of preliminary injunction in prison conditions case); *Jones ’El v. Burge*, 164 F. Supp. 2d 1096, 1123 (W.D. Wis. 2001) (“Put more specifically, pain, suffering and the risk of death constitute

⁶⁵ Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19), World Health Organization (Feb. 28, 2020), at 12, <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> (last visited Apr. 1, 2020).

irreparable harm sufficient to support a preliminary injunction in prison cases.” (internal quotation marks omitted)).

Even the failure to *test* for a disease has been sufficient to support a finding of irreparable harm. *See Boone v. Brown*, 2005 WL 2006997, at *14 (D.N.J. Aug. 22, 2005) (allegation of refusal to provide adequate testing for highly contagious infectious disease sufficient to demonstrate irreparable harm); *Austin v. Pa. Dep’t of Corr.*, 1992 WL 277511, at *7 (E.D. Pa. Sept. 29, 1992) (granting preliminary injunction for prison to develop testing and protocol for Tuberculosis); *see also Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) (state officials have an affirmative obligation to protect prisoners from infectious disease).

Courts around the country faced with the same dangers at other correctional facilities have specifically held that COVID-19 constitutes an irreparable harm that supports the grant of a TRO. *See, e.g., Thaker, et al. v. Doll, et al.*, No. 20 C 0480, Dkt. 47 (M.D. Pa. Mar. 31, 2020); *Basank v. Decker*, No. 20-cv-2518, 2020 WL 1481503 at *4-5 (S.D.N.Y. March 26, 2020) (“The risk that Petitioners will face a severe, and quite possibly fatal, infection if they remain in immigration detention constitutes irreparable harm warranting a TRO.”); *Castillo v. Barr*, No. 20-cv-00605, 2020 WL 1502864, at *6 (C.D. Cal. Mar. 27, 2020) (granting a TRO to immigration detainees due to the COVID-19 pandemic explaining that “[t]his is an unprecedented time in our nation's history, filled with uncertainty, fear, and anxiety. But in the time of a crisis, our response to those at particularly high risk must be with compassion and not apathy. The Government cannot act with a callous disregard for the safety of our fellow human beings.”); *United States v. Doshi*, No. 13-cr-20349, 2020 WL 1527186, at *1 (E.D. Mich. Mar. 31, 2020) (granting home confinement for remaining sentence of inmate who is 64 years old and suffers from diabetes and hypertension in light of threat COVID-19 presented to him at prison

facility); *Xochihua-Jaimes v. Barr*, No. 18-cv-71460, 2020 WL 1429877, at *1 (9th Cir. Mar. 24, 2020) (“In light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers, the court *sua sponte* orders that Petitioner be immediately released from detention and that removal of Petitioner be stayed pending final disposition by this court.”).

In *Thaker*, the district court recognized that “the *status quo* of a mere few weeks ago no longer applies. Our world has been altered with lightning speed, and the results are both unprecedented and ghastly The choice we now make must reflect this new reality.” *Thaker*, No. 20 C 0480, Dkt. 47 at 24. The district court found that even though the conditions in the local federal detention facilities were not insufficient because of intent or malice, “should we fail to afford relief” to medically vulnerable prisoners “we will be a party to an unconscionable and possibly barbaric result.” *Id.*; *see also id.* (“Our Constitution and laws apply equally to the most vulnerable among us, particularly when matters of public health are at issue.”). The district court accordingly granted a temporary restraining order requiring the immediate release of 11 prisoners in federal custody who suffer from chronic medical conditions and face a serious threat of injury or death if exposed to COVID-19. *Id.* at 2, 24–25.

Courts in other cases have similarly recognized the need for a TRO in light of the danger prisoners face in custody. *Coronel v. Decker*, No. 20-cv-2472, 2020 WL 1487274, at *3 (S.D.N.Y. Mar. 27, 2020). As the court in *Coronel* explained, that is so both because of the high probability of death for those infected with COVID-19—particularly for inmates with medical conditions—and because being confined in a correctional facility places a person at “significantly higher risk of contracting COVID-19.” *Id.* As Plaintiffs have explained at length in this Memorandum, the harm that the Class Members are threatened with right now at

Stateville is the definition of irreparable. Confined in Stateville, the Class Members are subject to a rate of infection by COVID-19 that is more than nearly forty times higher than that of the surrounding population. If they contract the infection, a substantial number of patients are so wracked by COVID-19 that they are unable to breath without the help of a machine—and even then, in the case of older and medically vulnerable patients, a substantial number of them will die. The Class Members, in short, are subject to a substantial risk of a catastrophic injury from which there is no recovery. Plaintiffs respectfully submit that the Class Members face a substantial risk of serious harm if the relief requested herein is not granted expeditiously.

III. Threatened Harm to Class Members Outweighs Any Harm to Defendants.

The threatened harm to Class Members is imminent and grave. Class Members face significant risk to their health and many risk losing their lives if they are infected with the virus due to their medical conditions and/or age. The harm Class Members face due to COVID-19 crisis at Stateville, particularly those most vulnerable of incurring severe complications and possibly death if they contract COVID-19, outweighs any possible harm to Defendants. Defendants may contend that they will need to expend additional time or expense to provide information to an appointed COVID-19 monitor or that it is unnecessary oversight. But, additional time or sharing information and oversight hardly constitute harms. And, even if these were actual “harms,” which they are not, they are greatly outweighed by the severe health risks and even death that Class Members face at an increasing rate. *See, e.g., Lewis v. Gen. Employment Enterprises, Inc.*, No. 91 C 0291, 1991 WL 11383, at *3 (N.D. Ill. Jan. 21, 1991) (TRO granted where plaintiffs’ harm greatly outweighed the defendants’ harm that only “prevent[ed] a shareholder vote taken pursuant to potentially false and misleading information.”). To the contrary, it serves the public, Defendants, and the staff that work at

Stateville, who are also at greater risk of infection, to ensure that all reasonable efforts are made reduce the risk of infection of COVID-19.

IV. Consideration of the Public Interest Favors Plaintiffs' Requested Relief.

It is always in the public interest to prevent the continuing violation of a plaintiff's constitutional rights. *See Joelner v. Vill. of Washington Park, Ill.*, 378 F.3d 613, 620 (7th Cir. 2004) (“[s]urely upholding constitutional rights serves the public interest) (quoting *Newsom v. Albemarle County Sch. Bd.*, 354 F.3d 249, 261 (4th Cir.2003)); *see also Preston*, 589 F.2d at 303 n.3 (“[t]he existence of a continuing constitutional violation constitutes proof of an irreparable harm, and its remedy certainly would serve the public interest.”). And in this case the public interest in minimizing the spread of COVID-19 is overwhelming and nearly impossible to overstate.

Finally, the public interest favors the Court granting Plaintiffs' requested relief. Class Members seek to have their health and safety provided for during this time of global crisis so that they do not needlessly perish. Indeed, the requested relief greatly serves the residents of this State to ensure that Defendants act in accordance with the law to provide conditions that reduce as much as reasonably possible the risk of infection from COVID-19. *See Basank, P.G. ex rel. K.G. v. Hamos*, No. 13-3020, 2013 WL 393233, at *6 (C.D. Ill. Jan. 31, 2013) (granting TRO for severely mentally ill children to require the State of Illinois to provide adequate in home or alternative care as required by Medicaid Act explaining that “[t]he court further finds that issuing a temporary restraining order in this case will not harm the public interest. Ordering the State of Illinois to provide Plaintiffs with medical treatment that the State is required to provide under the EPSTD provisions of the Medicaid Act will not harm the public interest.”). More concretely, it is in the public's great interest that Stateville contain its spread of COVID-19 so that the outbreak

at Stateville does not consume and exhaust medical and health resources that are needed in other parts of the community and State. St. Joseph's hospital has already faced on onslaught of Class Members in need of hospital beds, critical care resources and ventilators. Plaintiffs' requested relief promotes and serves the all of the public's interest in combating this pandemic as effectively as possible and reducing as much harm and death as we can collectively achieve with our best efforts. *See, e.g., Basank*, 2020 WL 1481503, at *6 ("Given the large population density of immigration detention centers and the ease of transmission of this viral pathogen, the attack rate inside these centers will take exponential proportions, consuming significant medical and financial resources.") (citing *Urgent action needed to prevent COVID-19 "rampaging through places of detention"* – *Bachelet*, UNHCR (Mar. 25, 2020), <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25745&LangID=e> (United Nations High Commissioner for Human Rights urging that detention of people in jails "should be a measure of last resort, particularly during this crisis"))).

V. This Court Should Not Require Plaintiffs to Provide Security Prior to Issuing a Temporary Restraining Order.

Under Rule 65(c) of the Federal Rules of Civil Procedure, district courts have discretion to determine the amount of the bond accompanying a preliminary injunction, and this includes the authority to set a nominal bond. In this case, the Court should waive bond because Plaintiffs are indigent, the requested preliminary injunction is in the public interest, and the injunction is necessary to vindicate constitutional rights. *See Pocklington v. O'Leary*, 1986 WL 5748, at *2 (N.D. Ill. May 6, 1986) ("[B]ecause of [a prisoner's] indigent status, no bond under Rule 65(c) is required."); *Davis v. Mineta*, 302 F.3d 1104, 1126 (10th Cir. 2002) ("minimal bond amount should be considered" in public interest case); *Complete Angler, L.L.C. v. City of Clearwater*, 607 F.Supp.2d 1326, 1335 (M.D. Fla. 2009) ("Waiving the bond requirement is particularly appropriate where a plaintiff alleges the infringement of a fundamental constitutional right.")).

CONCLUSION

Wherefore, Class Members respectfully seek an emergency, temporary appointment of a Special Master agreeable to both parties to assess the IDOC's response to the COVID-19 outbreak at Stateville, and to ensure that the health, safety and lives of Class Members is being protected. Class Members seek an individual or individuals with expertise in correctional facility management as well as infectious disease and/or public health: (1) segregating Class Members who are exhibiting symptoms of infection from healthy Class Members; (2) reducing the spread of the virus through all necessary health and sanitation recommendations; (3) instituting social distancing for living, daily activities like eating and showering; (4) providing PPE to Class Members to reduce the spread of the virus; and (5) ensuring all possible means are used to segregate any Class Members whose age or prior medical conditions puts them at increased risk of developing severe medical complications if they contract COVID-19.

Respectfully submitted,

CLASS MEMBERS

/s/ Sarah Grady

Sarah Grady

One of Class Members' Counsel

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CERTIFICATE OF SERVICE

I, Sarah Grady, an attorney, certify that I filed Plaintiff's Emergency Motion for Temporary Appointment of a Special Master on April 2, 2020, and thereby caused all counsel of record to be served via the Court's ECF/CM electronically filing system.

/s/ Sarah Grady_____

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, on behalf of himself	)	
and all others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 1

COVID-19 Response

 www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx

Confirmed Cases

Locations	Staff Confirmed	Incarcerated Individuals Confirmed
Crossroads ATC	1	0
Joliet Treatment Center	1	0
Menard	1	0
North Lawndale ATC	1	4
Sheridan	1	0
Stateville	16	48
Stateville NRC	4	0

COVID-19 Testing Among Incarcerated Population

Number of Tests Completed	Number of Negative Results	Number of Positive Results	Number of Pending Lab Results
0	0	0	187

Administrative Quarantine

All correctional facilities, Impact Incarceration Programs, and work camps are currently under Administrative Quarantine with no visits. Regular phone and video visit privileges will continue as normal. Administrative Quarantine is an intentional form of restricted movement within a facility to accommodate for unusual needs or circumstances, such as a pandemic outbreak. This measure must be taken to ensure the health and safety of those who live and work in our facilities.

We will continue to ensure men and women in custody receive all necessary treatment and services:

- Showers
- Medical and mental health treatment
- Alternative educational, clinical and substance abuse programming
- Access to the phone and GTL kiosks
- Cleaning supplies
- Law Library
- Commissary
- Leisure Time Services

Lockdown

Facilities with confirmed cases of COVID-19 are placed on lockdown, which means there is no movement around the facility except for medical care. Staff who work with individuals in isolation and quarantine, as well as in healthcare units, are wearing full personal protective equipment (PPE) and all staff are wearing some PPE.

News

Public Health Officials Report Death of Incarcerated Man

New Admissions Suspended

Governor JB Pritzker issued an executive order suspending all admissions to the Illinois Department of Corrections from all Illinois county jails. The Director of IDOC will work closely with county Sheriffs and other partners in the criminal justice system to discuss any potential exceptions that may be necessary.

Questions about IDOC's Response to COVID-19?

A list of frequently asked questions can be found here.

The Department has established a support line for questions regarding COVID-19. The call center can be reached Monday through Friday 8:30 AM - 4:30 PM at 217-558-2200 ext. 7700. Questions can also be emailed to doc.covid@illinois.gov. For any medical-related questions, please contact the Illinois Department of Public Health at 1-800-889-3931 or dph.sick@illinois.gov.

Employee Resources

The health and safety of staff is a top priority for the Department. These employee resources will be updated as new information becomes available.

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Plaintiffs,	)	
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v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 2

Stateville Correctional Center

 www2.illinois.gov/idoc/facilities/Pages/statevillecorrectionalcenter.aspx

David Gomez, Warden

Facility Data

Stateville Correctional Center

Opened: March 1925

*Operational Capacity: 1,252

Maximum Security Adult Male

**Stateville Correctional Center Population: 1,173

**Northern Reception and Classification Center Population: 1,302

**Stateville Minimum Security Unit: 199

**Total Population: 2,674

Average Annual Cost Per Offender: \$41,195 (FY18)

*Operational capacity is the maximum amount of beds a facility has; to include all health care, crisis, segregation, protective custody, isolation, R&Cs, and future beds that are down for repair. Data reflects a bed space capacity census that was conducted in CY19.

**As of 6/20/19

Stateville Correctional Center is the parent institution for the Northern Reception and Classification Center and Stateville Minimum Security Unit.

Visiting Hours

The facility is on lockdown. No visits are allowed

Visitor ADA Accommodations

IDOC Visitation Rules and Information

Visitors to any correctional facility will be required to produce photo identification and verification of date of birth. Please be sure to bring **2 forms of identification with you**; these would include a current photo ID such as a driver's license, a state ID card, government ID card, military ID/driver's license, or acceptable documentation of non-U.S. citizenship including a current Passport, or Visa, documentation must contain the visitor's

date of birth. Expired forms of identification will not be accepted. Visitors will also be required to provide vehicle information and other pertinent data, such as government identification, official credentials, attorney registration, and or law student certification.

Maximum security visits are 8:00am to 2:30pm (daily)

Minimum security visits are 8:00-7:30pm (weekends and holidays)

Visitors must arrive by 1:30 pm weekdays and 12:45pm weekends & holidays.

General population and protective custody inmate visits are limited to two hours on weekdays and one hour on weekends and holidays. All segregation inmate visits are limited to one hour.

Video Visitation Hours

Sunday through Saturday 4:00p to 8:00p

Visitors should log on to the GTL 15 minutes prior to the scheduled start time.

Video Visitation Guidelines

Facility Address

Business Mail:

16830 So. Broadway St.
P.O. Box 112
Joliet, IL 60434

Inmate Mail:

Inmate Name & IDOC#
P.O. Box 112
Joliet, IL 60434

Phone: (815) 727-3607

Fax: (815) 727-5511

Facility Information

Stateville Correctional Center's mission is to encourage and promote a climate of safe and secure conditions in which offenders and staff can develop positive attitudes and encourage work and program opportunities and experiences that guide offenders toward reintegration into the community.

The facility sits on a total of 2,264 acres of land with a 33-foot wall with guard towers surrounding it. This adult male maximum security facility consists of a 32-bed infirmary in the health care unit and three living units that house general population, segregation, protective custody and temporary writ inmates. The Northern Reception and Classification Center (NRC) functions as the major adult male intake and processing unit for the entire state. The NRC contains 1,800 beds in 24 housing units. Within the NRC is also the minimum-security unit, which can house up to 384 offenders in two units.

Inmate Programs

Academic:

- ABE (Adult Basic Education)
- GED (General Education Development)

Vocational:

Barbering

Industries:

- Soap
- Recycling

Volunteer Services

- Creative Art
- Choir
- Religious Bible Studies

Postsecondary Education:

- North Park University – Master of Arts in Christian Ministry and Restorative Arts Degree
- Northwestern University – Bachelor of Arts with Associates of Arts through collaboration with Oakton Community College
- Northeastern University / University Without Walls Program (UWW) – Competency based Bachelor Degree
- DePaul University – Inside Out Program; credit bearing class
- Behavior Modification
- College Think Tanks
- Long Term Offender Program (LTO)/Creative Writing/Creative Art
- Houses of Healing
- Further Learning

- Communication Skills/Math Skills
- Finance Skills/Grief Group
- Twelve Step Program

Other:

- Library
- Life Skills
- Anger Management
- Substance Abuse
- Life Style Redirection
- Chaplaincy/Religious Programming
- Veterans Group
- Community Work Crews
- Counseling

**IN THE UNITED STATES DISTRICT COURT FOR THE
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	)	
Plaintiffs,	)	
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	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 3

Declaration for Persons in Detention and Detention Staff
COVID-19

Chris Beyrer, MD, MPH
Professor of Epidemiology
Johns Hopkins Bloomberg School of Public Health
Baltimore, MD

I, Chris Beyrer, declare as follows:

1. I am a professor of Epidemiology, International Health, and Medicine at the Johns Hopkins Bloomberg School of Public Health, where I regularly teach courses in the epidemiology of infectious diseases. This coming semester, I am teaching a course on emerging infections. I am a member of the National Academy of Medicine, a former President of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. I have been active in infectious diseases Epidemiology since completing my training in Preventive Medicine and Public Health at Johns Hopkins in 1992.
2. I am currently actively at work on the COVID-19 pandemic in the United States. Among other activities I am the Director of the Center for Public Health and Human Rights at Johns Hopkins, which is active in disease prevention and health promotion among vulnerable populations, including prisoners and detainees, in the US, Africa, Asia, and Latin America.

The nature of COVID-19

3. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the WHO. Cases first began appearing sometime between December 1, 2019 and December 31, 2019 in Hubei Province, China. Most of these cases were associated with a wet seafood market in Wuhan City.
4. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
5. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.3 to 3.5%, which is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.
6. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate is higher in men, and varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardio-vascular disease, respiratory disease, diabetes, and immune compromise.
7. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS) which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical

ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and in parts of China.

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents, heavily affected countries include Italy, Spain, Iran, South Korea, and the US, now the world's most affected country. As of today, March 29th, 2020, there have been 713,171 confirmed human cases globally, 33,597 known deaths, and some 149,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.
9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.
10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0 , is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.
12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.
13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.
14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities. Limits on soap (copays are common) and hand sanitizer, since it can contain alcohol, are also risks for spread.
15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in

multiple detention facilities in China, associated with introduction into facilities by staff. The current outbreak in the detention facility of Riker's Island in New York City is a example—and in the first days of that outbreak the majority of cases were among prison staff, not inmates.

16. In addition to the nature of the prison environment, prison and jail populations are also at additional risk, due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death from COVID-19 disease.
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.
18. Pre-trial detention should be considered only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, should be prioritized for release. Immigrants awaiting decisions on their removal cases who are not a flight risk can be monitored in the community and should be released from immigration detention centers. Older inmates and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) should be considered for release.
19. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are highly likely. Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 16th day of March, 2020.

A handwritten signature in dark ink, appearing to read "Chris Beyrer". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Professor Chris Beyrer

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**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, on behalf of himself	)	
and all others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 4

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.
2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.
3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.
4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
5. I am being paid \$1,000 for my time reviewing materials and preparing this report.
6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.
9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.
10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.
11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.
12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.¹ This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.
14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.
15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.
16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.
18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

¹ *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31251-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext).

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.² Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.³ Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease⁴

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

² *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012),

<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

³ David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), <https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/>.

⁴ This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, <https://www.cdc.gov/coronavirus/2019-ncov/index.html>; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), <https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections>.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.⁵ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.⁶ Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.
22. The care of people who are infected with COVID-19 depends on how seriously they are ill.⁷ People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.
24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.⁸ To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

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

⁶ *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*. *The Lancet* (published online March 11, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext)

⁷ *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

⁸ *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), <https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5>.

place.⁹ Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice: New Jersey, Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.
26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.
27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.
28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.
29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.
30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

⁹ Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), <https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690>.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.
32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.
33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.
34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.
35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

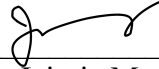
36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.
37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.
38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.
39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.
40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

March 15, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, on behalf of himself	)	
and all others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 5

DECLARATION OF DR. CRAIG W. HANEY, PHD

I, Craig W. Haney, declare as follows:

1. I am a Distinguished Professor of Psychology and UC Presidential Chair at the University of California Santa Cruz in Santa Cruz, California, where I engage in research applying social psychological principles to legal settings including the assessment of the psychological effects of living and working in institutional environments, especially the psychological effects of incarceration. I was a co-founder and co-director of the UC Criminal Justice & Health Consortium – a collaborative effort of researchers, experts and advocates from across the University of California system working to bring evidence-based health and healthcare solutions to criminal justice reform in California and nationwide.

2. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations). In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate in a hearing that focused on the use and effects of solitary confinement and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. My research, writing, and testimony have been cited by state courts, including the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court¹.

3. COVID-19 is a serious, highly contagious disease and has reached pandemic status. At least 741,774 people around the world have received confirmed diagnoses of COVID-19 as of March 30, 2020, including 140,570 people in the United States. At least 35,334 people have died globally as a result of COVID-19 as of March 30, 2020, including 2,443 in the United States². These numbers are predicted by health officials to increase, perhaps exponentially. For example, the CDC has estimated

¹ For example, see *Brown v. Plata*, 563 U.S. 493 (2011).

² World Health Organization, *Coronavirus disease (COVID-19) Outbreak*, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>; and Center for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

that as many as 214 million people may eventually be infected in the United States, and that as many as 21 million could require hospitalization³.

4. The COVID-19 Pandemic poses such a threat to the public health and safety in the State of Illinois, that on March 20, 2020 Governor Pritzker declared all counties in Illinois to be disaster areas and ordered all Illinois residents to stay home or at their place of residence except to facilitate certain authorized necessary activities⁴. On March 26, 2020, Illinois' Governor Pritzker issued Executive Order 13⁵, which barred all transfers of people from the county jails to the Illinois Department of Corrections, based on (among others) the following findings:

WHEREAS, the Illinois Department of Corrections ("IDOC") currently has a population of more than 37,000 male and female inmates in 28 facilities, the vast majority of whom, because of their close proximity and contact with each other in housing units and dining halls, are especially vulnerable to contracting and spreading COVID-19; and,

WHEREAS, the IDOC currently has limited housing capacity to isolate and quarantine inmates who present as symptomatic of, or test positive for, COVID-19...

5. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. Currently, the most effective ways to control the virus are to use preventive strategies, including social distancing, in order to maximize our healthcare capacity for a manageable number of patients. Otherwise, healthcare resources will be overwhelmed and the Pandemic will worsen.

6. Social distancing presents serious challenges for everyone in every part of our society, but nowhere more than in penal institutions, where living conditions are unusually sparse and prisoners necessarily live in unescapably close quarters with one another.

7. Moreover, jails and prisons are already extremely stressful environments for the persons confined in them.⁶ They can be psychologically and medically harmful

³ Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths*, N.Y. TIMES (Mar. 18, 2020), <https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html>

⁴ Executive Order 2020-10 (<https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-10.aspx>)

⁵ Executive Order 2020-13 (<https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-13.aspx>)

⁶ Much of this evidence is summarized in several book-length treatments of the topic. For example, see: Haney, C., *Reforming punishment: Psychological limits to*

in their own right, rendering prisoners unusually vulnerable to stress-related and communicable diseases. Formerly incarcerated persons suffer higher rates of certain kinds of psychiatric and medical problems.⁷ Incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die).⁸

8. Prisons lack the operational capacity to address the needs of persons in custody in a crisis of this magnitude. These facilities are ill-equipped to provide incarcerated persons with ready access to cleaning and sanitation supplies, or to assure that staff sanitize all surfaces during the day. Prisoners are surrounded by and enveloped in hard metal surfaces, precisely the kind on which the COVID-19 virus lives longest.

9. Most correctional facilities were already operating at or beyond the limits of their capacities to provide mental health or medical care long before the COVID-19 Pandemic began. Many are located in remote geographical locations where access to ICU beds and ventilators in surrounding community hospitals are extremely limited. The demand for such services in this crisis will only grow, and already

the pains of imprisonment. Washington, DC: American Psychological Association (2006); Liebling, A., & Maruna, S. (Eds.), *The effects of imprisonment*. Cullompton, UK: Willan (2005); and National Research Council (2014). *The Growth of Incarceration in the United States: Exploring the Causes and Consequences*. Washington, DC: The National Academies Press. In addition, there are numerous empirical studies and published reviews of the available literature. For example, see: Haney, C., *Prison effects in the age of mass incarceration*. *Prison Journal*, 92, 1-24 (2012); Johns, D., *Confronting the disabling effects of imprisonment: Toward prehabilitation*. *Social Justice*, 45(1), 27-55.

⁷ E.g., see: Schnittaker, J. (2014). The psychological dimensions and the social consequences of incarceration. *Annals of the American Association of Political and Social Science*, 651, 122-138; Turney, K., Wildeman, C., & Schnittker, J., *As fathers and felons: Explaining the effects of current and recent incarceration on major depression*. *Journal of Health and Social Behaviour*, 53(4), 465-481 (2012). See, also: Listwan, S., Colvin, M., Hanley, D., & Flannery, D., *Victimization, social support, and psychological well-being: A study of recently released prisoners*. *Criminal Justice and Behavior*, 37(10), 1140-1159 (2010).

⁸ E.g., see: Binswanger, I., Stern, M., Deyo, R., et al., *Release from prison: A high risk of death for former inmates*. *New England Journal of Medicine*, 356, 157-165; Massoglia, M. *Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses*. *Journal of Health and Social Behavior*, 49(1), 56-71; and Massoglia, M., & Remster, B., *Linkages Between Incarceration and Health*. *Public Health Reports*, 134(Supplement 1), 85-145 (2019); and Patterson, E. (2013). *The dose-response of time served in prison on mortality: New York state, 1989-2003*. *American Journal of Public Health*, 103(3), 523-528.

scarce treatment resources will be stretched even more. If Illinois does not act immediately to reduce its prison population, COVID-19 is likely going to spread rapidly throughout its prisons, overburdening the prison medical care program and surrounding community hospitals, resulting in likely deaths. In fact, the first death of an Illinois prisoner (at Stateville prison) was announced on March 30, 2020. More are sure to follow if action is not taken.

10. In addition, prisons typically provide very limited access to telephonic or other forms of remote visiting. Yet precisely these ways of connecting to others will become critically important if contact visiting is limited. Furthermore, prisons have only limited means of protecting incarcerated persons from contact with staff who regularly enter facilities after having been in the outside world. Staff members are at risk of having contracted COVID-19 and then transmitting it to all those inside the institutions, including staff and incarcerated persons.

11. In penal settings, the social distancing that is now required in response the COVID-19 Pandemic will most likely take the form of solitary confinement. Indeed, I have seen precisely this form of social distancing utilized as a matter of course in numerous correctional institutions throughout the country, where medical quarantines are conducted in prison infirmaries or other housing units by effectively placing prisoners in solitary confinement.

12. Yet solitary confinement subjects people to a separate set of very serious harmful effects, ones that significantly undermine their mental and physical well-being. The scientific literature on the harmfulness of solitary confinement in jails and prisons is now widely accepted and the research findings are consistent and alarming.⁹ This research has led a number of professional mental and physical health-related, legal, human rights, and even correctional organizations to call for

⁹ These many studies have been carefully reviewed in a number of publications. For example, see: K. Cloyes, D. Lovell, D. Allen & L. Rhodes, Assessment of psychosocial impairment in a super-maximum security unit sample, *Criminal Justice and Behavior*, 33, 760-781 (2006); S. Grassian, Psychiatric effects of solitary confinement. *Washington University Journal of Law & Policy*, 22, 325-383 (2006); C. Haney, Restricting the use of solitary confinement. *Annual Review of Criminology*, 1, 285-310 (2018); C. Haney & M. Lynch, Regulating prisons of the future: The psychological consequences of solitary and supermax confinement. *New York Review of Law & Social Change*, 23, 477-570 (1997); and P. Smith, The effects of solitary confinement on prison inmates: A brief history and review of the literature, in Michael Tonry (Ed.), *Crime and Justice* (pp. 441-528). Volume 34. Chicago: University of Chicago Press (2006).

severe limitations on the degree to which solitary confinement is employed—specifically limiting when, for how long, and on whom it can be imposed.¹⁰

13. I was retained as an expert by the plaintiffs in the Illinois case, *Davis v. Jeffreys*, 3:16-cv-600, pending in the United States District Court for the Southern District of Illinois. In connection with my work in that case, I toured the segregation units, yards, health care units, and crisis cells in six Illinois prisons: Stateville, Pontiac, Menard, Dixon, Logan, and Lawrence.

14. After touring these prisons, interviewing scores of prisoners both at cell front and in longer confidential interviews, and reviewing hundreds of medical records and master files, I concluded then that the conditions that existed there created very serious risks to the lives and well-being of persons with mental illness. I concluded that even those without a pre-existing mental illness were at a considerable risk of psychological harm if they were to be housed in these segregation units. I urged that strict time limits on such confinement be applied and that significant out of cell time with other prisoners would be required to reduce these risks.

15. Based on my many years of studying correctional systems and practices across the country, I know that ameliorative measures such as increased treatment and out of cell time will be among the first things that are suspended as the prison system diverts staff to address the Pandemic. I am told that much of the mental health treatment and programming in Illinois prisons has stopped, including that the Department will be reducing out of cell contacts and relying more heavily on non-confidential and cell front checks in lieu of needed confidential treatment and out of cell time.

16. In fact, the Illinois Department of Corrections has already announced on its COVID-19 update page¹¹ that it has imposed an “Administrative Quarantine” statewide, which has (despite the claim that “leisure time services and mental health treatment will continue) generally limits movement and person-to-person contact, and thus shifted virtually the entire prison system to programs (or lack thereof) that are even more restrictive than the solitary confinement or segregation programs that I observed and critiqued throughout the system during my tours.

¹⁰ For a list of these organizations and their specific recommendations, see: Haney, C. (2018) Restricting the use of solitary confinement. *Annual Review of Criminology*, 1, 285-310; Haney, C., Ahalt, C., & Williams, B., et al. (2020). Consensus statement of the Santa Cruz summit on solitary confinement. *Northwestern Law Review*, in press.

¹¹ <https://www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx> (last accessed March 30, 2020).

Mentally ill prisoners are especially likely to suffer and be harmed as a result of these policies

17. It is my opinion that, unless immediate measures are taken to reduce the population of persons with serious mental illness in the Illinois prison system needless suffering and loss of life are likely to occur.

18. With these things in mind, it is my professional opinion that adult prisons must reduce their populations urgently in order to allow the necessary social distancing in response to the COVID-19 Pandemic.

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

Executed on March 31, 2020 at Santa Cruz, California.

Dr. Craig W. Haney Ph.D.
DR. CRAIG W. HANEY, PHD

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, on behalf of himself
and all others similarly situated,

Plaintiffs,

v.

MICHAEL STUDER, et al.,

Defendants.

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)
)
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)
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)
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Case No. 13 C 1068

Hon. Robert M. Dow, Jr.

EXHIBIT 6

**Statewide Summary Report Including Review of Statewide Leadership
and Overview of Major Services**

Report of the 2nd Court Appointed Expert

Lippert v. Godinez

October 2018

Prepared by the Medical Investigation Team

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other state prison systems nationwide.²¹ IDOC Spending in 2017 is still below the average 2015 spending of prisons nationwide.

Ten Lowest Per Capita Expenditures for Health Care in US State Prison Systems in 2015	
State	Per Capita Annual
Louisiana	\$2,173
Alabama	\$3,234
Indiana	\$3,246
Nevada	\$3,246
South Carolina	\$3,478
Arizona	\$3,529
Georgia	\$3,610
Illinois	\$3,619
Kentucky	\$3,763
Mississippi	\$3,770

For most state systems, the number of employees, age, and percent of female population were the largest drivers of cost of prison health programs. The Federal Bureau of Prisons assessed that institutions with the highest percentages of aging inmates spent five times more per inmate on medical care and 14 times more per inmate on medication than institutions with the lowest percentage of aging inmates. The National Institute of Corrections estimates that inmates over age 55 cost, on average, two to three times more than the expense for all other inmates.²² Based on this same 2017 report, Illinois has the seventh *lowest* rate of persons over age 55 (8.5%). As well, in 2015 IDOC had a female population of 5.8%, the ninth *lowest* rate of females incarcerated in state prison systems. These two factors should lower the costs of care somewhat, but are not so great as to account for the difference in IDOC cost from the mean health expenditure of state prison systems.²³

Staffing appears to be the biggest contributor to the low IDOC spending on health care. In fiscal year 2015, Illinois has the second lowest number of full-time equivalent (FTE) health care workers (19.3 per 1,000 inmates) of all 50 state prison systems. The range of FTEs per 1,000 in the 50 state systems range from 18.6 FTEs per 1,000 inmates to 86.8 FTEs per 1,000 inmates.²⁴

²¹ In his deposition, Mr. Brunk the Chief Financial Officer for the IDOC stated on pages 12-13 that the total expenditures on health care in the IDOC were approximately \$203 million. Using a population of approximately 42,000 the expenditures per inmate per year would be approximately \$4,800.

²² Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

²³ Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

²⁴ Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

There is a direct correlation between the FTEs per 1,000 inmates and per-inmate annual spending. A low number of staff can reflect a more efficient system of care or understaffing with its attendant negative consequences for provision of health care. In our study, we found that in 2018 there were 25 employees per 1,000 inmates, which still places Illinois approximately in the lower 10% of state prison systems based on 2015 data. This will be discussed later in this report.

Key Findings

Overall, the health program is not significantly improved since the First Court Expert's report. Based on record reviews, we found that clinical care was extremely poor and resulted in preventable morbidity and mortality that appeared worse than that uncovered by the First Court Expert.

Governance of the IDOC medical program is subordinated to custody leadership on a statewide level and at the facility level. The subordination of health care to custody leadership has resulted in a medical program that is not managed on sound medical principles and one that is without medical leadership.

The existing IDOC system of care was established to have a more robust central office capable of monitoring vendor activity. The IDOC central office has been progressively diminished over the years to the point where it is incapable of effective monitoring.

The medical program does not have a separate budget. The IDOC could not provide to us a document that included expenditures for medical care. Authorization and responsibility for medical expenditures does not reside with the health authority.

IDOC Administrative Directives are inadequate policies for this state system. The IDOC medical policies need to be refreshed, augmented, and address all National Commission on Correctional Health Care (NCCHC) standards.

The IDOC does not have a staffing plan that is sufficient to implement IDOC policies and procedures. The staffing plan does not incorporate a staff relief factor.

Custody staffing has also not been analyzed relative to health care delivery to determine if there are sufficient custody staff to deliver adequate medical care.

Budgeted staffing was increased but vacancy rates were higher than noted in the First Court Expert's report. Staff vacancy rates are very high.

list of major responsibilities or tasks, except for addressing questions of the physician staff. Because neither IDOC nor Wexford performs effective review of clinical care of physicians, poorly performing physicians continue to perform poorly without apparent oversight. We noted this on multiple chart reviews and mortality reviews.

Wexford Regional Medical Directors are also responsible for ensuring patient care is consistent with community standards.⁴³ Yet we found many examples of physicians providing care inconsistent with current standards of care that appear to be systemic practices. For example, IDOC does not provide colorectal cancer screening based on current standards of care and does not appear to routinely screen patients with cirrhosis for varices or hepatocellular carcinoma. Persons with chronic obstructive lung disease (COPD) are not provided pulmonary function testing, which is a cornerstone of management of COPD. The current management of lipid disorders is not in line with current standards or with the Office of Health Services treatment guideline. We will discuss these later in the Chronic Disease section of this report. These deficiencies need to be corrected because these deficiencies have caused morbidity and mortality. There is no evidence of participation of the Wexford Regional Medical Team in identifying these deficiencies to the IDOC or ensuring that their physicians are practicing based on contemporary standards of care.

With respect to facility leadership, administrative supervision by HCUAs at individual facilities has improved since the First Court Expert's visit. The IDOC HCUAs are responsible for administrative operational supervision of each facility. Of the 26 HCUA positions, all but one is now filled. However, two of the HCUAs also serve as acting Regional Coordinators, making them much less effective as HCUAs. Effectively, only 23 of 26 HCUA positions are filled. HCUAs were all competent and were engaged in solving administrative problems, even though some problems appeared unrecognized. This is one of the most significant and positive advances since the First Court Expert's report and is a strength that the program can build on.

Medical Directors are all Wexford positions. Of the 26 Medical Directors statewide, 8.5 (33%) are vacant.⁴⁴ This is an enormous vacancy rate for this key leadership position. Approximately only half of physicians have training in primary care, which will be discussed later in this report. This is a very small percentage of physicians trained in primary care. When a Medical Director is not trained in primary care it is very difficult to be responsible for monitoring performance of medical staff rendering direct patient care. An untrained physician is not likely to know how that care is supposed to be provided. We found that onsite monitoring of clinical care was very poor to nonexistent.

Director of Nursing (DON) positions can be either Wexford or IDOC. Fifteen (58%) of the DON positions are staffed by Wexford. Eleven (42%) are staffed by the IDOC. Seven (27%) of DON positions are vacant; four DON vacancies are Wexford positions and three DON vacancies are

⁴³ Regional Medical Director's Responsibilities as provided by Wexford Health Sources.

⁴⁴ Illinois Medical Vacancy Report with ASRs as of 6/18/18 provided by the Attorney General's Office from Wexford Health Sources. This report gives staffing at all facilities as of 6/18/18.

IDOC positions. Nursing staff can be either IDOC or Wexford, making it difficult, because of co-employment rules,⁴⁵ to properly supervise line staff.

Of the 78 leadership positions (Medical Director, DON, and HCUA) at the 26 facilities, 16.5 (21%) are vacant. The vacant positions are compounded by co-employment issues⁴⁶ and use of two HCUAs as Regional Coordinators. The leadership vacancies are significant on a statewide basis. The lack of Medical Directors is dramatic and is compounded by using physicians in these positions who are, in our opinion, unqualified by virtue of not having primary care training.

In summary, administrative supervision by HCUAs is adequate but clinical-medical supervision and management, particularly physician care, is inadequate and places patients at significant risk of harm. The clinical supervision at the facility level is inadequate based on Medical Director and DON vacancies, and poor qualifications of physicians.

IDOC Policy

The IDOC provides policy direction on clinical care through its Administrative Directives and chronic care guidelines. The medical Administrative Directives are a part of the larger IDOC Administrative Directives which include all custody policy. We will discuss the chronic disease guidelines in the section on Chronic Disease and dental guidelines in the Dental section. The Medical Administrative Directives are inadequate with respect to the breadth of guidance that is necessary for a correctional medical program. The IDOC has only 18 Administrative Directives. In comparison, the National Commission on Correctional Healthcare⁴⁷ has 68 standards, which is a minimum panel of policies for a large prison system. There are essential areas of service that are not governed by Administrative Directives and thereby are not guided by policy and not standardized statewide. Though each facility can have additional institutional policies and procedures, the lack of statewide guidance means that practices are not standardized. The Office of Health Services needs to be responsible for statewide policy guidance in all areas of service, with local policy following statewide policy. The 18 medical Administrative Directives are inadequate for this purpose. The National Commission on Correctional Health Care standards are a reasonable guideline to determine the scope of processes of care that should be governed by Administrative Directives.

Wexford Provider Staffing and Physician Credentialing

It is our opinion that the quality of physicians in the IDOC is the single most important variable in preventable morbidity and mortality, which is substantial. The first step in provision of quality of care is to ensure appropriately credentialed medical staff. In its response to the First

⁴⁵ Co-employment means that there are two employers (IDOC and Wexford), each of whom has some legal responsibility for the same employees.

⁴⁶ When a State employee HCUA is responsible for managing the health care unit but staff are Wexford, there are some limitations with respect to discipline and assignment as a result of union rules. When a DON is a Wexford employee and staff nurses are state employees, the same occurs. These co-employment issues affect multiple facilities we visited.

⁴⁷ The National Commission on Correctional Healthcare is the leading organization establishing standards for correctional health programs.

Court Expert's report,⁴⁸ on page 4 an attorney for the State states that, "More than 80% of WHS' [Wexford Health Services] physicians are either Board Certified in Family Practice or Internal Medicine, or have more than 10 years of Family/Internal Medicine practice experience or correctional medical experience." This is a misleading statement that gives an inaccurate representation of the credentials of physicians. Credentialing information provided by Wexford shows that only six (20%) of the physicians are board certified in a primary care field. Because physicians typically work alone in these facilities, experience alone is no guarantee that performance will improve to be consistent with current standards of care. We document multiple preventable deaths in the mortality review section of this report. It is our opinion that poorly credentialed physicians contribute significantly to those preventable deaths.

Currently, there are 30 Wexford physicians working in IDOC facilities. Of these, only 16 (53%) have completed training in primary care. Of the 16 that completed primary care training, only six (20% of the 30) are board certified in primary care. Two doctors are obstetricians who work at LCC doing women's care, for which they are appropriately credentialed and privileged; one of these is board certified. These doctors only provide obstetrical and gynecological care, not primary care. Five physicians have an internship or a year or two of primary care training but did not complete a residency.⁴⁹ The remaining seven include:

- One anesthesiologist
- One doctor with two years of occupational medicine
- One doctor with some training in pathology
- One doctor with a year of physical medicine
- One surgeon
- Two radiologists, one of whom did not complete residency training.

Credentialing is a process whereby a physician's qualifications are evaluated by reviewing their education, training, experience, licensure, malpractice history, and professional competence with respect to the work they will be expected to perform. Proper credentialing is the foundation of protecting patient safety. Credentialing must ensure that a physician is properly trained for the work they will be performing. Credentialing protects patient safety by preventing incompetent, *poorly trained*, or impaired physicians from engaging in patient care. In correctional facilities, the scope of practice required and the health care needs of patients are mostly primary care, which requires physicians who have residency training in a primary care field. However, the only requirement in the IDOC with respect to credentialing is to verify that a physician has a license. A Regional Coordinator testified that the only review of credentials is to verify that the doctor has a license, and that their training, board certification, or disciplinary history is not part of credentialing review.⁵⁰

⁴⁸ Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.

⁴⁹ This information comes from items 4229081-4228845-Part 1; 4229082-4228845-Part 2; 4229085-4228845-Part 4; 4229088-4228845-Part 3; and 4229090-4228845-Part 5. This credentialing information was provided by Wexford Health Sources, Inc.

⁵⁰ Deposition of Joseph Ssenfuma, Regional Coordinator, on September 28, 2017.

Privileges are the services and procedures that a physician is qualified to perform based on training and experience. The credentials and training of a physician determine what privileges that physician should have. As an example, a doctor who is trained and credentialed in general surgery can obtain privileges to perform appendectomies and cholecystectomies. A physician trained and credentialed in obstetrics can obtain privileges to deliver babies. Physicians trained and credentialed in internal medicine or family practice can obtain privileges to practice primary care. Physicians trained and credentialed in internal medicine cannot obtain privileges to deliver babies or perform appendectomies. And physicians trained and credentialed in radiology or general surgery cannot obtain privileges to provide primary care. Because the scope of practice and needs of the patients in a correctional medical program are primary care, physicians should be credentialed and privileged in primary care. In IDOC, physicians are credentialed to perform primary care even when they have no training in primary care. This is a serious problem with the credentialing process. For this reason, we agree with the First Court Expert that Medical Directors be board certified in a primary care specialty. Given the size of the IDOC facilities, there is only one physician on staff at most facilities. When this physician is not trained in primary care, there is no other available physician to care for the patient.

Because there are so many physicians who have not completed a primary care residency, the level of supervision of their care should be at a higher level than for board certified physicians. This is not the case. There is no special monitoring for this group. All physicians receive the same type of peer review.

Peer review is a means to monitor the quality of physician and other provider care, and thereby protects patient safety. Peer review of physicians in the community is typically of two types. One type of peer review is done on a routine basis for all physicians and is done as a monitoring device to ensure quality of care. This type of peer review is often called performance evaluation program or PEP. A second type of peer review is done when a member of the medical staff may have committed a serious gross or flagrantly unacceptable error or exhibits a serious character or behavior problem and needs to be evaluated with respect to possible reduction of privileges or referral to a medical board. The latter type of peer review is generally a formal quasi-legal procedure that has significant implications for the physician's employment and professional status. We found that the first type of peer review is done for all physicians and mid-level providers in the IDOC, but the second type of peer review does not appear to occur in IDOC, based on information made available to us. As will be detailed later in the mortality review section of this report, there were numerous grossly and flagrantly unacceptable episodes of care that should have resulted in peer review but did not. Peer review in the IDOC is ineffective, as physicians who commit repeated egregious medical errors continue to practice and continue to harm patients.

The first type of peer review which is performed by Wexford is a structured questionnaire performed by one Wexford physician on another Wexford physician. We noted at one facility that a general surgeon performed the peer review of the primary care work of a nuclear radiologist. It is our opinion that this type of performance evaluation is defective and unlikely to

result in meaningful evaluation, as neither doctor is adequately trained to practice primary care and would not be able to know when care was adequate.

Also, the peer review that is done is so poor that it is unlikely to identify problems. The Wexford peer review consists of a review of 10 single episodes of care for five areas of service. For each of these areas of service there are a series of questions ranging from 10 to 15. Some of the questions are not relevant to clinical quality, such as:

- Is the handwriting legible?
- Is the signature with professional designation legible?
- Is the patient enrolled in all relevant clinics?
- Are all medications written on a script?
- Does the clinic include pertinent vital signs?

While it is important to write a legible note, legibility does not evidence clinical competence. Many questions require an interpretation. For example, the question “Was treatment appropriate for this visit” requires that a physician know the appropriate treatment. The problem is that when only 20% of doctors are board certified and 23% have no training in primary care, many doctors will not know the appropriate treatment. Doctors performing these evaluations need to be expected to know what the appropriate treatment is, otherwise the test will not perform as expected. Also, these episodes of care are picked at random and may not include patients that have serious illness. When someone does not have a serious illness, it is difficult to test the clinician, because it is very difficult to make an error if there is no decision to make with respect to the treatment. Additionally, it appears that these reviews are not taken seriously and appear to be done merely because these are requirements of the contract. For these reasons, it is not surprising that almost all peer reviews were scored 100% adequate. When we compare these results with death chart reviews we performed, there is dramatic discrepancy. Most chart reviews we performed contained many errors. We reviewed the care provided over two years prior to the death. Of 33 death charts we reviewed, there were over 1700 errors. Many had serious errors. Some had egregious errors that resulted in death. We noted the same level of medical error in chart reviews we performed on site visits. The Wexford methodology of peer review does not appear to accurately review physician practice, based on a comparison to our record review of clinical care. This process is not working as intended.

The First Court Expert opined that Wexford hired underqualified physicians, and recommended that facility Medical Directors be trained in primary care and be board certified. We agree with this finding, based on the credentialing information above, and we agree with his recommendation.

In reviewing the Defendants’ comments to the First Court Expert’s Draft Report,⁵¹ the Defendants challenged the assertion of the First Court Expert that Wexford Health Services has hired “underqualified clinicians.” In their attempt to refute that assertion, the Defendants

⁵¹ Re: Lippert v. Godinez – Defendants’ comments regarding Confidential Draft Report via email dated November 3, 2014, authored by William Barnes.

stated that, “The community standard, as espoused by the American Medical Association, requires physicians to possess only a license to practice medicine.” This is misleading and inaccurate. This statement implies that the current community standard of medicine is for physicians to only have a license to practice medicine, presumably in any field. We disagree. It is our opinion that the community standard in the U.S. is for physicians working in primary care to have residency training in a primary care field. One would never see a pathologist delivering babies. The Defendants’ statement also implies that the American Medical Association (AMA) endorses their position. This statement of Defendants is neither the community standard nor is it a standard we could identify as espoused by the AMA.

It is true that it is legal for a doctor without residency training to open a private practice in the community and practice primary care medicine without any training in primary care. However, it is becoming increasingly uncommon, and particularly in urban areas, it is now extremely uncommon to find doctors without residency training in primary care who work in general practice. The standard in the community is for physicians in organized medical practices to undergo credentialing and privileging, and to have residency training consistent with their scope of practice.

With respect to the recommendation to hire board certified physicians, the State’s response said,

“This recommendation, along with any recommendations dictating specific training or certification for licensed correctional physicians, lacks any justification or support in state law and community, ACA, AMA, and NCCHC standards. Accordingly, this recommendation *exceeds minimum constitutional standards of adequacy*” [my emphasis].⁵²

With respect to the assertion that use of board certified primary care physicians exceeds minimum constitutional standards of adequacy, we note as an example that there has been Federal Court intervention requiring use of primary care trained physicians when that training was necessary to protect inmate-patients. For years, the California Department of Corrections and Rehabilitation (CDCR) had poorly credentialed physicians, which resembled the current situation in the IDOC. In 2004, in the California prison system, many physicians were not trained in primary care; instead, they had training in surgery, radiology, gynecology, pathology, etc., similar to the IDOC situation in 2018. Many physicians had prior or current sanctions of their licenses and evidence of clinical incompetence by virtue of malpractice claims, which we were unable to evaluate for Wexford physicians. It was the opinion of the Court in California that the lack of qualified physicians resulted in increased morbidity and preventable death. We believe that the situation in California is similar to the situation in the IDOC. In California, as a result of that situation, the Federal Court issued an order⁵³ requiring the use of physicians who were

⁵² Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.

⁵³ Proposed Stipulated Order Re: Quality of Patient Care and Staffing; Marciano Plata, et al., v. Arnold Schwarzenegger, et al.; United States District Court Northern District of California No. C-01-1351 T.E.H., originally filed 9/17/04. In that order, the Court stated: “As of January 15, 2005, defendants shall not hire independent contractor primary care physicians who are not board-eligible or board certified in internal medicine or family practice.” p. 3.

board certified or board eligible⁵⁴ in internal medicine or family practice.⁵⁵ We note that in the California prison system in 2007, there were 18 preventable and 48 potentially preventable deaths, and in 2017, when all physicians were required to be board certified, there were 0 preventable deaths and 18 potentially preventable deaths.⁵⁶ Although there were other systemic improvements that helped reduce the number of preventable deaths, improvements in physician credentialing played the major role. Improving credentials of physicians and removal of unqualified physicians has been shown to reduce mortality.⁵⁷

We have learned that in the mid-1980s, approximately 12 IDOC prison facilities were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). At that time, the Agency Medical Director approved all facility Medical Directors and his requirement was that Medical Directors completed primary care training. Accreditation by JCAHO required privileging based on appropriate credentials. At that time, the IDOC placed into its Administrative Directives the requirement that all physicians have one-time primary source verification of their credentials, which was a requirement to verify training. The IDOC ended their accreditation with JCAHO but kept in the Administrative Directives the requirement of primary source verification. Over the years this practice was ignored and currently the HCUAs we interviewed do not even know what primary source verification is. The only credentialing review is to ensure at the annual CQI meeting that every physician has a license.

Physician Staffing

Physician staffing in IDOC is very poor. The Vice President of Operations for Wexford could not remember the last time there was a full physician staff. She thought in 2014 there was only one vacancy, but that was as close to full staffing as the program got. We noted earlier in this report that IDOC lacks adequately trained physicians. This is compounded by vacancies in physician positions. Persistent and ongoing vacancies in the Medical Director position title contribute significantly to physician staffing deficiencies. In addition to vacancies of Medical Directors, all five facilities we visited were missing a physician. Two facilities had replaced a physician position with a nurse practitioner because of the inability to fill physician positions. Statewide, the total days of missing Medical Directors totaled 22% of total days these positions were supposed to be filled,⁵⁸ an unacceptable vacancy rate.

Because of vacancies, physicians are moved from site to site as “Traveling Medical Directors.” One of the facilities we investigated, NRC, had a Traveling Medical Director. This individual did

⁵⁴ Board eligible is a term used to describe a physician who has completed a residency training in a field and is therefore qualified to take a board certification test for that specialty. For example, a board eligible internist is one who has completed a residency in internal medicine and is qualified to take the board certification test but has not yet done so.

⁵⁵ Since this order, the California Department of Corrections and Rehabilitation, through the Receiver’s office, requires board certification in family practice or internal medicine.

⁵⁶ Based on annual analyses of inmate deaths as reported by Dr. Imai, consultant to the medical receiver in California as found under the heading of Death Review at <https://cchcs.ca.gov/reports/>.

⁵⁷ Terry Hill, Peter Martello, Julie Kuo; A case for revisiting peer review: Implications for professional self-regulation and quality improvement. Plos One at <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0199961&type=printable>.

⁵⁸ Document 42P5621-IDOC Facilities lacking permanent medical directors 7-1-15 to 11-26-17 Bates number 550.

not participate meaningfully in quality improvement, did not show any evidence of oversight of the medical program, and had clinical issues.

The turnover of Wexford physicians is also very high. Of 33 physicians listed on a 9/19/14 report⁵⁹ by Wexford, only 18 (54%) are still working three and a half years later. The inability of Wexford to hire and *retain* qualified physicians is a serious problem and was mentioned as a significant problem by every HCUA we spoke with. There has been no formal analysis of this that we could find. The Vice President of Operations for Wexford told us that it was harder to recruit to corrections because of the impression that if you worked in corrections, you were a bad doctor. We disagree. In our opinion and from experience, recruitment in corrections depends on establishing conditions of work that are professional and foster a sense of providing a worthwhile service. When that occurs and when doctors are properly supported, qualified doctors can be found and retained in correctional environments and elsewhere.

At the five sites we visited, none had a long-tenured Medical Director. LCC had a Medical Director who had the longest tenure of the five facilities we inspected. She had been Medical Director since May of 2016. The Medical Director at Dixon started in October of 2017. The Medical Director at MCC has been in his position since June of 2017. One Medical Director was at Dixon for a short period of time before being moved to NRC. After several months at NRC, he was moved to SCC. About two months after being moved to SCC, he resigned. His position at NRC was filled in coverage by the ex-Medical Director at Hill, who the First Court Expert stated had identified clinical issues. This musical chairs rearrangement of Medical Director assignments is demonstration of the failure to create an environment likely to attract qualified physicians. The IDOC needs to determine why it is that their vendor cannot recruit and retain qualified physicians.

Physician leadership was not improved based on the First Court Expert's comment that,

“the Medical Directors were functioning in primarily clinical roles and spent little if any time reviewing the clinical practice of other providers or engaging in other important administrative duties.”⁶⁰

Several of the HCUAs spoke about poor physician quality as an issue. Two of the Medical Director positions were vacant. A coverage physician at one facility with a vacant Medical Director position did not participate meaningfully in quality work or in providing clinical leadership. In two of the remaining three facilities we visited, the HCUA spoke of having problems with the Medical Director. One was described as only doing chart reviews, not wanting to see patients, not reviewing deaths, and having to be urged to see patients. When leadership and quality of physicians is inadequate, patients are placed at risk because poor quality will not be identified or corrected.

⁵⁹ 40C0134- IL Physicians Report 9 19 14 Key Produced by Wexford Health Services.

⁶⁰ Final Report of the Court Appointed Expert, Lippert v. Godinez December 2014 p. 7.

Non-Physician Staffing

On a statewide basis, exclusive of dialysis and the HIV and hepatitis C telemedicine program, there are 1119.6 medical staff in the IDOC program, with an inmate population at mid-year 2017 of 43,075. This amounts to 26 staff per 1000 inmates, which places IDOC approximately in the lowest 10% of state prison systems in the country⁶¹ with respect to staffing numbers *based on 2015 data*. Of the 1119.6 staff, 401 (36%) are employed by IDOC and 718.6 (64%) are employed by Wexford Health Sources. Of the 1119.6 medical staff, there are 245.8 (22%) vacancies, not including leave of absences, which would increase this number a few points. Wexford has an 18% vacancy rate for its 718.6 employees and IDOC had a 29% vacancy rate for its 401 employees. These are very high vacancy rates and compound a very low staffing level, making staffing a critical problem statewide. This was confirmed by HCUAs at sites we visited.

We compared facility staffing for mutually visited facilities. In 2014, the First Court Expert determined that for the five facilities we visited there were 303.41 budgeted positions, an 18% vacancy rate, and 25 staff per 1000 inmates.

Positions, Vacancies, and Positions per 1000; First Court Expert's 2014 visit⁶²

Facility	Positions	Vacancies	% Vacancy	Population	Staff per 1000
SCC & NRC	73.90	23	31%	4078	18
LCC	62.21	4	6%	1997	31
Dixon	66.30	18	27%	2349	28
MCC	101	9	9%	3750	27
Total	303.41	54	18%	12174	25

For the same five sites we visited, there were 405.05 budgeted positions. There were 99 (23.5%) vacancies. This is a very large vacancy rate, which makes it difficult to effectively operate a health program.⁶³ Four of the five facilities we visited had unacceptable vacancy rates.⁶⁴ We note several key differences in the staffing differences between 2014 and 2018. The population in the five facilities we reviewed decreased by 2177 (18%). The number of positions

⁶¹ Prison Health Care: Costs and Quality, Pew Charitable Trusts, October 2017. We note that the staffing levels given in the Pew study reflect 2015 numbers. However, these 2018 IDOC staffing numbers still would rank Illinois in the lowest 10% of state prison systems comparing IDOC 2018 staffing to nationwide 2015 numbers.

⁶² This table is constructed from data taken from tables presented in the First Court Expert's report.

⁶³ In Defendants' comments on our report they noted that there is a national nursing shortage and cite a survey of readily available health care facilities in the United States in January 2018 by Nursing Solutions, Inc. a recruitment firm. Defendants note that over 25% of the hospitals in this country who responded to the survey have Registered Nurse (RN) vacancy rates of greater than 10%. This same study reported that the average vacancy rate for Registered Nurses is 8.2%. In either case, nursing vacancies in the IDOC facilities we visited exceeded the average from this survey and were much more than the maximum of 12.5% used in the study.

⁶⁴ Except for LCC, all IDOC facilities had vacancy rates of 20% or greater. These vacancy rates are much higher than Federal Bureau of Prisons policy that establishes that vacancy rates not exceed 10% during any 18-month period (Program Statement P3000.03: Human Resources Management Manual, Chapter 3, page 11 obtained at <https://www.bop.gov/PublicInfo/execute/policysearch#>). There are no published reports comparing vacancy rates amongst health care providers working in state prison settings.

increased by 101.64 (33%).⁶⁵ The staff per 1000 inmates increased by 16 (64%). But the vacancy rate increased from 18% to 23.5%, a 30% increase.

Positions, Vacancies, and Positions per 1000 Inmates; 2018 visits

Facility	Wexford and IDOC staff	Vacancies	% Vacancy	Population	Staff per 1000
SCC	98.00	24	24%	1183	83
NRC	69.00	29	42%	1681	41
LCC	53.15	1	2%	1806	29
Dixon	93.80	19	20%	2298	41
MCC	91.10	26	29%	3029	30
Total	405.05	99	23.5%	9997	41

While budgeted staffing increased at three of five facilities we visited, it decreased at two of five facilities. There are 44 additional staff working at these facilities than there were when the 2014 report was written.

Four of five facilities we visited had significant vacancy rates, as high as 42%, which are mostly nursing staff. Almost every HCUA told us that there were insufficient nursing staff. This was confirmed in the deposition of the Agency Medical Coordinator, who noted that over the past several years there have been nursing shortages at SCC, Pontiac, Decatur, Graham, Southwestern, and MCC.⁶⁶

Most HCUAs told us that if all their positions were filled they believed that there would be adequate staff. We do not agree. The IDOC has not performed a staffing analysis based on expectations of the Administrative Directives and special care needs, including infirmaries and geriatric care. Relief factors have not been included in staffing considerations and budgeted staffing numbers do not appear to be adequate. In our opinion, despite increased nurse budgeted staffing and even when vacancies are filled, there will still be nursing shortages. The IDOC, in their comments on our report, assert that the IDOC in the current fiscal year and Wexford in the past year spent a total of \$8,283,718 on overtime wages. We acknowledge that this is a significant expenditure. Based on our investigation, overtime is used to cover some but not all vacant shifts. However, reliance on overtime contributes to staff fatigue, increased errors, staff dissatisfaction and turnover as well as higher incidence of poor patient outcomes.⁶⁷ While we did not evaluate working conditions for staff, we did find ample evidence of error and

⁶⁵ Dixon appears to have had a significant increase in staffing, but as the HCUA related to us, this is artefactual, as 22 nurses were moved from the mental health program to the medical program but still had assignments in mental health. Their reassignments did not create increased staffing for the medical program, but gave the impression that there had been a large increase in staffing. If these 22 nurses are removed from the Dixon staffing, the actual increase in staffing would be 79.64 positions or a 26% increase, not a 33% increase.

⁶⁶ Deposition of Kim Hugo, Agency Medical Coordinator pp. 25-31, April 11, 2018.

⁶⁷ Institute of Medicine (2004) Keeping Patients Safe: Transforming the Work Environment of Nurses. National Academies Press, Washington, D.C., Stanton, M. (2004). Hospital nurse staffing and quality of care. Agency for Healthcare Research and Quality. Research in Action, Issue 14.

poor patient outcomes in our review of health care provided to IDOC prisoners. The use of overtime does not change our opinion that a staffing analysis is needed or that there is lack of adequate staffing.

The Wexford component of staffing is memorialized in a contract document called a Schedule E. Based on interviews with senior leadership of Wexford and IDOC, we could not determine who is responsible for developing staffing levels found in the Schedule E. The Wexford Vice President of Operations told us that the Schedule E staffing is the recommended staffing of the IDOC to which the vendor can make suggestions. Mr. Brunk, the Chief Financial Officer, told us that the Schedule E is developed by the Wexford Regional Manager and reviewed by the IDOC Office of Health Services. The Agency Medical Director told us that he had input into the Schedule E for new facilities but otherwise had no input into the Schedule E, and that Mr. Brunk or Wexford developed the Schedule E, which the Office of Health Services approved. The Chief of Programs and Support Services, who is the health authority, told us that the Agency Medical Director was responsible for development of the Schedule E. Development of the Schedule E is not in the job description of the Agency Medical Director. The lack of a central health authority, we believe, contributes to this confusion. Furthermore, the Schedule E as represented in the current contract does not include input from HCUAs, Regional Coordinators, or even the Agency Medical Director in addressing clinical needs in their facilities. Given these responses, it is our opinion that the Schedule E does not reflect actual staffing need, as it does not appear based on any staffing analysis we could identify after discussions with health leadership who we thought would be responsible for this document.

No one we spoke with has responsibility for determining if total staff (state and Wexford) is adequate. The IDOC Agency Medical Director and the Agency Medical Coordinator told us that an Assistant Warden of Programs (AWP) from Sheridan, who also was a nurse, was engaged in analyzing staffing at various sites, but the extent of this analysis was not known to the Agency Medical Director. The Illinois Nursing Association (INA) is the union for the registered nurses in the IDOC. The Agency Medical Coordinator participates on an INA standing committee that meets monthly to discuss INA related nursing issues. The INA has raised issues with respect to staffing at certain facilities. When this occurs, the AWP from Sheridan performs a staffing analysis, brings it to the standing committee, which then considers staffing recommendations, and forwards them the Agency Medical Director for review. Other than this effort, we could identify no analysis of staffing need state wide.

Based on conversations with senior IDOC leadership, staffing increases at NRC and SCC were a result of union negotiations. Senior IDOC Office of Health Services staff were not involved in this decision,⁶⁸ although a Regional Coordinator gave recommendations on how many nurses were needed. These increases were not based on a thorough staffing analysis, as relief factors were not used and because no positions other than RN positions were considered. At no facility has there been an analysis of staffing need based on adherence to the Administrative Directives. This creates a gap between clinical need and staffing levels that affects all facilities.

⁶⁸ See pages 14-16 of deposition of Kim Hugo, Agency Medical Coordinator, April 11, 2018.

the Warden. This appears to have resulted in procedures that accommodate custody needs even when it results in medication administration practices that violate nursing practice standards.

Further, we observed nurses floating medication well in advance of administration, which alters the medication's properties, and crushing medication that was put in the reused envelopes, which contaminates other medications put into the envelope. These practices put inmates at risk of receiving ineffective treatment and adverse drug reaction.

Medication Continuity

Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed. Chronic disease medications are provided to patients either as "Keep on Person" (KOP) or each dose is administered by a nurse. We found many examples of patients whose ordered medications were never provided, were delayed starting, and were stopped because the patient had not been seen by a provider to renew medication. Record reviews indicated that appointments for chronic care are not scheduled to take place prior to expiration of chronic disease medication orders. As a result, providers often reorder medications without seeing the patient to conduct a clinical evaluation to determine whether the treatment plan should be continued or changed, based upon the how well the patient's chronic disease is controlled.

Facility policy and procedures¹⁶² direct that the MAR be available with the medical record at the time of a chronic care provider visit. However, we saw no evidence that current MARs were available at the time a patient saw a provider. We also saw no evidence that providers review the MAR and discuss the patient's adherence as part of chronic care appointments. Facility policy and procedures¹⁶³ also instruct nurses to refer patients to a provider for evaluation and possible change in treatment if they refuse to take prescribed medication. In the records we reviewed, there were multiple examples of patients not taking medication as prescribed who were not referred for provider evaluation.

Monitoring Performance

Pharmacy audits and inspections, which are done routinely, document the problems described above. These reports are reviewed and included in the institution CQI meetings. They document ongoing problems system wide with medication, including: use of the envelope rather than MAR to prepare medication; failure to document medication given on the MAR; failure to transcribe orders onto the MAR; administering medication for which there was no order, or when the inmate was not present at the facility; administering medications that differ from the order; documenting in advance that medication was administered; and the presence of open, undated, multi-use containers of medication. There has been some coaching and

¹⁶² LCC, SCC, and DCC Operations Policy and Procedure P. 107 Management of Chronic Disease and MCC Policy and Procedure V3-12 Medical management of offenders with a chronic condition. No policies and procedures were provided for NRC.

¹⁶³ LCC, SCC, and DCC Operations Policy and Procedure P. 128 Medication Services and MCC Policy and Procedure V 4-1 Pharmacy Services. No policies and procedures were provided for NRC.

counseling of individuals, but there has been no review or analysis done to identify root causes for these persistent failures, and no effort made to eliminate systemic causes of failure or improve performance through corrective action planning. In the meantime, inmates are subjected to delays and interruptions of treatment, unsanitary conditions, and medication errors.

We note that some of the root cause problems appear to be related to custody control of medical processes within the institution and the apparent reluctance of health staff to openly discuss with custody the need for their cooperation in the process of medication administration. The governing bodies of CQI committees at several facilities were mostly custody-trained staff. This is an impediment to effective monitoring of clinical processes, such as medication treatment. Participation and support of custody staff in CQI is very important; however, medical staff must direct and control the monitoring of health care and be able to drive necessary performance improvements.

Infection Control

Infection control is an essential element of an adequate health care system. The inmate population has a high prevalence of communicable and infectious diseases. Because of the high prevalence of communicable diseases, a highly functioning infection control program must be in place to identify, track, and assist in management of these illnesses.

Approximately 4-6% of TB cases reported in the United States occur among people incarcerated at the time of diagnosis. The incarcerated population contains a high proportion of people at greater risk of TB than the overall population.¹⁶⁴ In 2013, there were 36,064 persons with HIV infection in the civilian population of Illinois, with a population over 18 years old of 9.7 million or 0.4% of the population. In 2010-2015, IDOC had 686 inmates with HIV infection or 1.5% of its population.¹⁶⁵ The IDOC HIV prevalence was almost four times as high as the civilian HIV prevalence. It is estimated that approximately 160,000 persons in Illinois have hepatitis C or about 1.6% of the Illinois population, as opposed to 5.6% known cases in IDOC and an estimated 10% overall estimated prevalence. The IDOC had at least 3.5-6.25 times the rate of hepatitis C infection of the civilian population. The burden of sexually transmitted disease, MRSA, and scabies are also typically higher in prison systems.

Conditions of confinement promote the spread of disease because of environmental conditions within the prisons. Inmates are housed in close quarters. In our IDOC Prison Overview section we spoke about how crowded the IDOC prisons are. The overcrowded conditions, particularly in antiquated facilities, promote transmission of multiple types of infections and contagious diseases. Individuals have no control over the quality of air they breathe via the facility ventilation system; they live in cells or dormitories that have been occupied by others and are

¹⁶⁴ TB in Correctional Facilities in the United States, Centers for Disease Control and Prevention as found at <https://www.cdc.gov/tb/topic/populations/correctional/default.htm>.

¹⁶⁵ HIV in Prisons, 2015 – Statistical Tables, Laura Maruschak and Jennifer Bronson, Ph.D., BJS Statisticians; August 2017, NCJ 250641, US, Department of Justice *Bureau of Justice Statistics*.

expected to clean their living area with supplies that are available; they are provided food prepared by inmate workers to eat with silverware and plates cleaned by inmate workers; they are provided linens and clothing that are washed by inmate workers or wash linens themselves with laundry soap that is available; they use toilets, sinks, and showers that are used by many others. Every one of these activities of daily living carries multiple opportunities for communicable or infectious disease transmission and illness for both staff and inmates. Infection control programs in the correctional setting establish and monitor procedures to prevent exposure to diseases that can be transmitted in the correctional setting. Infection control programs also identify sources of infection through screening and take steps to prevent or mitigate infection of others, to treat persons with infectious diseases, and improve the health and safety of staff and inmates by providing information on prevention, education on self-care, and immunizations.¹⁶⁶ These efforts require surveillance of disease by accurate statistical means, both for required reporting purposes and so that the IDOC medical program can understand how to study, plan, and prepare for the care they will need to provide. The infection control program is usually coordinated by a registered nurse with consultation from a designated provider with expertise in infectious diseases,¹⁶⁷ and supported by data collection methods that can reasonably track diseases within the prison system.

First Court Expert Findings

The First Court Expert found IDOC's infection control program was a moving target across the system, with some facilities having well developed infection control programs and other facilities having programs described as being in their infancy. Facility health care staff had been provided with an exposure control manual, but IDOC provided no oversight of infection control. At some facilities, no one was clearly designated with responsibilities for infection control, and the duties were simply added to those of the HCUA or DON. Other facilities had identified a specific nurse responsible for infection control, but the duties of the position had not been defined. In addition, no training in how to operate an effective infection control program had been provided to those individuals who had been assigned responsibility for infection control.

Examples of systemic issues described by the First Court Expert which occurred as a result of the disarray in infection control monitoring and lack of oversight from IDOC included the failure to launder bed linens of infirmary patients in water temperatures hot enough to destroy pathogens transmitted by blood and body fluids; negative pressure rooms that were not functional and not monitored to ensure that negative pressure was maintained to prevent transmission of airborne illnesses; lack of proper sanitation of medical equipment; and lack of disinfection procedures to provide clean surfaces when examining patients.

Current Findings

The systemic issues described in the First Court Expert Report still occur today. While there has been some improvement in the use of paper barriers on examination tables, little else has

¹⁶⁶Bick, J. (2006) Infection Control in the Correctional Setting. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 230-231.

¹⁶⁷ Lane, M. (2006) The infection control program. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 460-461.

changed with regard to the infection control program. The following summary of our findings reinforces the findings of the First Court Expert. We had multiple additional findings that give us concern.

The IDOC has had numerous recent outbreaks of contagious and infectious diseases. Since 2008, there have been several outbreaks of scabies in Illinois prisons. The latest was in Taylorville in 2016, in which the prison was locked down and 214 inmates were treated.¹⁶⁸ In 2012, a norovirus outbreak sickened 140 inmates at SCC.¹⁶⁹ The numbers of inmates affected in these outbreaks reflects poorly on the surveillance and typical preventative measures enacted by infection control procedures to abort the contagion earlier and prevent the widespread infections that occurred at these facilities. An inmate at SCC also contracted Legionnaire's disease in 2015.¹⁷⁰ At the Danville Correctional Center, 78 persons were affected by histoplasmosis in 2013, likely from soil disruption. This outbreak was initially thought to be adenovirus, but required investigation by the federal Centers for Disease Control and Prevention and was found to be histoplasmosis.^{171, 172}

Typically, outbreaks such as these are monitored and sometimes managed by the infection control program. Yet in the IDOC, there was no designated individual responsible for infection control at four of five facilities we visited, including at SCC, where one of the outbreaks described above occurred, as well as the isolated case of Legionnaire's disease. At SCC, infection control duties were dispersed amongst several staff nurses, the DON, and the HCUA, and the program was not effective. The norovirus outbreak at SCC was large, and typically early infection control measures would be expected to reduce the size of such an outbreak. At the same four facilities there were no schedules for routine sanitation and disinfection of health care areas. Basic maintenance of rooms was lacking. MCC has an extensive collection of policies and procedures that detail cleaning and sanitation of every room in the health care building.

At MCC, responsibility for infection control resides with one of the nursing supervisors. Her responsibilities are managing TB surveillance, performing sanitation inspections, ensuring food handlers are cleared for work, monitoring skin infections, interface with the Illinois Department of Public Health, monitoring negative pressure rooms, and monitoring hygiene in clinical spaces. In addition, she manages HIV and hepatitis C clinics, coordinates follow-up of patients treated for TB infection, and provides supervision of inmate peer educators. It is our opinion that the infection control nurse is an essential component of the health care program at IDOC facilities and is a full-time position.

¹⁶⁸ Scabies Outbreak Causes Temporary Lockdown of Taylorville Prison, Doug Finke, The State Journal Register, September 19, 2016.

¹⁶⁹ Norovirus Outbreak Hits Illinois Prison; Food Safety News December 29, 2012.

¹⁷⁰ Stateville Inmate Diagnosed with Legionnaire's Disease, Dawn Rhodes, Chicago Tribune August 12, 2015.

¹⁷¹ New details regarding illness among inmates at Danville Correctional Center. Found at <https://www2.illinois.gov/idoc/news/2013/pages/danvilleccillness.aspx>.

¹⁷² Centers for Disease Control and Prevention website Outbreaks and Investigations lists Histoplasmosis in an Illinois Prison. Details given were that this occurred in August-September 2013 with 78 cases and likely related to disruption of soil containing bird droppings. Found at <https://www.cdc.gov/fungal/outbreaks/index.html>.

We observed significant challenges to safety and sanitation at every facility visited. For example, at SCC we observed cockroaches, gnats, and flies in the infirmary; the room used for hemodialysis (considered a sterile procedure) had peeling paint on the walls, there was standing water on the floor, and the garbage can was not covered. The kitchen/dining area was occupied by birds, and their droppings were evident on the walls and floors. At Dixon, all three floors of the medical building had missing floor tiles, which is a sanitation issue in an area dedicated to the delivery of health care.

NRC is the only facility among the five we visited that does not conduct monthly safety and sanitation inspections. At the other facilities, safety and sanitation inspections do not adequately identify problems requiring remediation. For example, we found faulty negative pressure isolation rooms and nonfunctional dental equipment that were not identified because they are not included in the safety and sanitation inspections. We also found furniture, equipment, and hard surfaces (floors, ceilings, sinks, cabinetry) were rusted, broken, or deteriorated in health care areas at all facilities, which had not been documented as issues needing repair on safety and sanitation rounds.

Moreover, review of safety and sanitation findings in the minutes of CQI meetings document the persistent failure or lengthy delay in remedying identified problems. Safety and sanitation inspections should inspect or monitor the condition, function, and annual certification of clinical equipment, functionality of the negative pressure rooms, integrity of bed and chair upholstery, completeness of medical cart and emergency response bag logs, the training of health care unit porters, and other health care issues.

The TB prevention and control program in IDOC is not effective. The hallmarks of an effective TB program in correctional facilities are: initial and periodic TB screening, successful treatment of TB disease and infection, appropriate use of airborne precautions, comprehensive discharge planning, and thorough and efficient contact investigation when a case of TB disease is identified.¹⁷³

At IDOC, TB screening is improperly performed, treatment of infection is delayed, and negative pressure rooms (an airborne precaution) often are not functional or monitored. We did not evaluate TB discharge planning or contact investigation, although in the absence of an individual assigned responsibility for infection control, these interventions are most likely sporadic and haphazard as well. At NRC, nurses do not read tuberculin skin tests properly and only document results in the health record when they have time. Instead of inmates being escorted to the medical clinic for nurses to read their tuberculin skin tests, nurses must go cell to cell. In addition, NRC officers do not open the food port for inmates to extend their arm for nurses to palpate and measure the results of the test. Instead, nurses read the test by looking through the glass window of the cell door, which is inappropriate technique.¹⁷⁴ There was

¹⁷³ TB in Correctional Facilities at <https://www.cdc.gov/tb/topic/populations/correctional/>, Epidemiology of Tuberculosis in Correctional Facilities 1993-2014 at <https://www.cdc.gov/tb/publications/slidesets/correctionalfacilities/default.htm>.

¹⁷⁴ A tuberculin skin test is read by manually palpating the size of induration of the test site with good overhead lighting. To read a tuberculin skin test through a glass window is inappropriate.

evidence in the review of records that other sites distrust TB screening performed at reception centers and rescreen inmates upon arrival at their parent facility. We also observed that nurses at Dixon merely look at the skin test site through the cell door rather than palpating and measuring induration in a well-lit area. We did not observe nurses reading tuberculin skin tests at all facilities, but based upon the two sites where we observed poor practices, we conclude that TB screening at IDOC is not adequate.

We reviewed the records of four patients who had completed treatment for latent TB infection. In three cases, the patient was subjected to multiple skin tests (which were positive) and multiple chest radiographs, which were unnecessary, before treatment was finally initiated. In the other case, treatment was initiated even though skin testing was ordered but never completed, based upon a history of a positive skin test reported by the inmate when he requested treatment initiation. Initiation of treatment for latent infection was haphazard and delayed.

Negative pressure isolation rooms were either not functional or the monitor was not working at three of the five sites we visited. At NRC, the monitor in one room was not working and in the other room the vent was taped shut, disabling the negative pressure. At SCC, neither room was functional and the equipment had not been serviced for years. At LCC, two of three rooms were not functional. Negative pressure rooms need to be maintained and ready for use; this is not the case in the IDOC, and places patients and staff at risk of airborne infection.

The UIC provides treatment of inmates with HIV and hepatitis C via telemedicine. For hepatitis C, UIC has no role in managing hepatitis C patients before referral and after antiviral treatment and has no role in screening for these diseases. UIC provides no assistance in managing other complications of hepatitis C including cirrhosis, varices, or ascites as examples. IDOC facility providers are responsible for that care but do not appear to know how to provide it. One or more nurses are designated at each site to coordinate these clinics and the care of these patients. The quality is highly dependent upon the interest and capability of each nurse assigned these responsibilities. There is no one identified to monitor or oversee the work of the clinic coordinators, who must negotiate with all the other users of the telemedicine space to schedule clinics timely. Coordination between the UIC infectious disease specialists and primary care providers is problematic, as evidenced in the example of one patient with HIV; the specialist recommended lowering the patient's dose of metformin (a medication used to treat diabetes) because of an interaction with one of the HIV medications prescribed.¹⁷⁵ The primary care provider at the facility responsible for the patient's diabetic care never acted on the recommendation. The HIV specialist reduced the dose of metformin at the next visit. The patient was at risk of clinical deterioration because of the primary care provider's omission for five months.

IDOC has adopted what it describes as opt-out HIV testing at intake, but policy and practice are not consistent with the use of this term. Opt-out testing is recommended by the Centers for

¹⁷⁵ Dixon Infection Control Patient #3.

Disease Control because it supports early identification and treatment.¹⁷⁶ The IDOC Administrative Directive still requires that consent be obtained before drawing blood for HIV, and in practice this consent is still obtained.¹⁷⁷ The practical effect is that fewer newly arriving inmates are screened for HIV as compared to hepatitis C. The IDOC should revise the Administrative Directive to eliminate the requirement for written consent and initiate opt-out HIV testing.

We also question the effectiveness of periodic screening programs for HIV and hepatitis C infections. We noted on one death review¹⁷⁸ a man who was not known to be HIV infected and was not offered HIV screening at two annual health evaluations we reviewed, despite having a history of multiple sexual partners, prior blood transfusions, and a history of sexually transmitted disease all of which were risk factors for HIV infection. He ultimately developed severe HIV disease, which was unrecognized for several years until he was finally admitted to a hospital, where he died of severe complications of his undiagnosed and untreated HIV disease. Sentinel cases such as these should prompt an investigation into why the system failed to timely screen, diagnose, and treat this patient, whose death was preventable. The infection control nurse should monitor results of HIV and HCV screening to verify that policies to screen for communicable diseases are effective.

All five of the facilities visited report cases of culture positive *Methicillin-resistant Staphylococcus Aureus* (MRSA) as is required by IDOC. However, only MCC tracks all skin and soft tissue infections (independent of whether a culture is performed) as recommended by the First Court Expert. In addition, tracking should include culture and sensitivity results to ensure correct antibiotic selection and housing location of the patient. Infection control nurses should review tracking results to identify clusters of infections by housing unit, perform additional case-finding, and identify environmental factors that may be promoting infection. Factors in correctional settings found to contribute to skin and soft tissue infections include sharing towels and soap, ineffective laundry practices, poor sanitation of exercise equipment and showering facilities, poor hygiene practices, unnoticed infections that leak pus, and poor access to medical care.¹⁷⁹ Tracking enables sources of infection to be identified and steps taken to eliminate factors associated with disease transmission. For example, at MCC one of two cases of skin infection reviewed was a patient who developed infection six days after hernia surgery and having been returned immediately to general population at the facility.¹⁸⁰ This case of soft tissue skin infection raises questions about the ability of the patient to adhere to wound care instructions and suggests consideration of a policy of admitting inmates to the infirmary only after it is determined that the patient is stable and able to adhere to wound care instructions.

¹⁷⁶ Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and it is performed only upon patient consent. The IDOC has large rates of refusal of HIV testing, unlike other similar correctional centers that offer opt-out testing. Opt-out testing generally raises the rates of screening.

¹⁷⁷ Administrative Directive 04.03.11 Section 5 II. F. 5. d.

¹⁷⁸ Mortality Review Patient #22.

¹⁷⁹ Smith, S. (2013) Infectious Diseases. In L. Schoenly and C. Knox (Eds.) *Essentials of Correctional Nursing*. New York: Springer. P. 189.

¹⁸⁰ MCC Infection Control Patient #7.

The IDOC requires a monthly report of communicable diseases and infection control data. This report includes items such as the number of MRSA cases, HIV and HCV tests performed, the number of tuberculin skin tests administered, the use of negative pressure rooms, etc. We found that these reports are submitted to the Quality Improvement Committee (QIC) and included in the monthly minutes. However, there is no trending or analysis of infection control data. There is no discussion in the infection control report or CQI minutes of, for example, why only half of incoming inmates are tested for HIV, given the statewide opt-out policy. A more notable example of the lack of introspection about communicable and infectious disease are three needle stick injuries which occurred in 2017 at Dixon, and the fact that there has been no focused review of these injuries to determine what measures would increase worker safety.

We found numerous examples of poor infection control practices on the part of health care professionals. At all facilities, inmates are not routinely provided eye protection during dental procedures. At NRC, the dentist examined patients without changing gloves between patients and reached into a bag of sterile mirrors to select one for use, contaminating all the other mirrors which were then used on subsequent patients. At SCC, the hemodialysis unit does not have a dedicated chair and technician for dialysis of patients who have hepatitis B, thereby exposing other dialysis patients to this blood borne infection. At NRC and SCC, paper barriers are not available to use on any of the examination tables and they are not cleaned between patients. Finally, the order in which instruments were sterilized was incorrect in four of five facilities we visited. The placement of sterilization equipment and procedures should proceed from dirty to sterilized. At four of five facilities we visited, the placement of the ultrasonic cleaner required clean instruments to pass over the dirty area, thus contaminating their sterilization. At SCC, sterilized instruments were removed from their packages and put in an open bin in the trauma room, making them clean, rather than sterile, instruments. The nursing supervisor could not explain why these instruments were clean rather than sterile.

Inmate porters are assigned to work in the health care areas of each of the five facilities we visited. At only two of the facilities had the inmate porters received training in how to clean and sanitize patient care areas, and how to take personal protective measures before working in the health care area. Only two facilities had vaccinated the inmate porters for viral hepatitis. The assignment of untrained and unvaccinated inmates to clean and sanitize health care areas exposes these inmates as well as patients receiving care to several infectious diseases with potentially serious health consequences, and is deliberately reckless.

Infirmiry linens are still laundered in residential style washers and dryers at all the facilities we visited, except NRC. At NRC, a log provided by the institution showed water temperatures were less than the 165°F required by AD 05.02.180 about 30% of the days reviewed. Water temperatures were not hot enough to effectively sanitize laundry from the infirmiry at any facility we visited. We also observed furniture and equipment throughout each of the health care areas at every facility we visited that was torn, frayed, rusted, and corroded. These objects, including stretchers, exam tables, stools, cabinets, and work surfaces cannot be properly sanitized and are sources of communicable disease in a setting that treats and cares for patients who are ill, medically fragile, and immunocompromised. While some have been

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LESTER DOBBEY, on behalf of himself	)	
and all others similarly situated,	)	
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Plaintiffs,	)	
	)	
v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 7

**Lippert V Jeffreys Consent Decree
First Report of the Monitor
November 24, 2019**

**Prepared by:
John M. Raba, MD
Monitor**

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I. Overview

The “Lippert v Jeffreys” Consent Decree was approved and signed by Judge Jorge L Alonso on May 9, 2019. John M. Raba, MD was selected as Monitor for the Consent Decree on March 29, 2019 with his IDOC contract being finalized on April 26, 2019. Provision V.G. of the consent decree states that “Every six months for the first two years and yearly thereafter, Defendants shall provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants’ compliance with the Decree and Defendant’s progress towards achieving compliance, with the Parties and Monitor agreeing in advance of the first report on the data and information that must be included in such report.” From May 20, 2019 through October 18, 2019, the monitor submitted requests on twenty separate dates for forty-three individual reports or categories of documents, data and information. The IDOC attorneys and clinical leadership have supplied the monitor with the majority of the requests with only few requests not yet fully received. On November 2, 2019, the monitor also submitted to the IDOC a more detailed comprehensive request for data and information for each and every provision of the consent decree. This comprehensive request will require a notable commitment of time and resources to compile; this additional data and information will provide a basis for the monitor’s second report that will be due in the Spring of 2020.

Since his appointment, the monitor has had regular meetings with IDOC Chief of Health Services (Agency Medical Director) and Deputy Chiefs of Health Services (Deputy Medical Directors) and regular communications with both the Plaintiffs’ and Defendants’ attorneys. The monitor interviewed the IDOC Director, the IDOC Deputy Director of Program & Support Services, the IDOC Electronic Health Record project manager, clinical and administrative leadership of medical/dental care vendor (Wexford Correctional Health Services), and the Rasho Consent Decree monitor.

concerned that the Collegial Review process presents a barrier to the access to offsite specialty consultation and tests, delays needed consultations, procedures, and testing, potentially puts patient-inmates' health at risk, and consumes an significant amount of physician, HCUA, medical records staff, Regional Health Coordinator, Agency Medical Director, and Deputy Chief resources. It is the preliminary opinion of the monitor that the Collegial Review should be eliminated and replaced by a selective utilization review process.

The Consent Decree (III.A.3) states that physicians who are not Board Certified (BC) in Internal Medicine, Family Medicine and Emergency Medicine or have not successfully completed a three residency (Board Eligible) in these three clinical fields shall be reviewed to determine whether they are providing a level of care that is consistent with competent BC and BE physicians. The physician credentials spread sheet provided to the monitor on October 14, 2019 revealed that twelve (34%) of the 35 physicians providing primary care in IDOC facilities had not completed a residency in Internal Medicine or Family Medicine (or Emergency Medicine). Seven of these twelve had been trained in non-primary care fields including Anesthesia, General Surgery, Nuclear Medicine/Radiation Therapy, Pediatrics/Neonatology, Surgery, Pathology, and Radiology. Three had only completed rotating general internships and two had not successfully completed their internal medicine residency programs. Methodology is being developed that would objectively determine whether the quality of care provided by these twelve non-Board Certified or non-Board Eligible physicians is safe and clinically appropriate. It is the opinion of the monitor that it is in the best interest of the IDOC patient population that all physicians providing primary care services in the IDOC should have successfully completed residency training programs in adult primary care fields. The only physician hired since the Consent Decree was approved had successfully completed a residency in Internal Medicine. The monitor is very supportive of the Office of Health Services efforts to establish relationships with the primary care training programs at University of Illinois at Chicago Medical Center and the Southern Illinois University School of Medicine that could assist IDOC with delivery of primary care and with future recruitment and retention of physicians with Board Certification or Board Eligibility in Internal Medicine or Family Medicine.

Data sheets provided to the monitor on August 6, 2019 documented that 7,265, nineteen percent (19%) of the IDOC were fifty years of age or older, nearly one thousand (2.6%) were between 65 and 79 years old and 61 were older than eighty years of age. The aging population in the IDOC is placing an increasing burden on the functioning of the correctional facilities and on the correctional health care

system. Men and women with various types of dementia, cerebrovascular accidents (CVA), advanced cancers, cardiovascular disease, and increasing fragility with risk of falls are housed in many of the IDOC facilities. The infirmaries are becoming filled with patient-inmates who are confused, incontinent, and require assistance with the basic activities of daily living including dressing, feeding, bathing, and toileting. The final staffing analysis will include significant augmentation in nursing personnel and support staff; many of whom will be assigned to infirmaries and geriatric units. The health care and correctional resources including staff, physical space, equipment, onsite support services and offsite specialty consultation, diagnostic testing, and hospitalization required to meet the needs of this aging population is staggering and will only increase if there is not a concerted and strategic effort to comprehensively address this situation. It is the position of the monitor that in the short term additional IDOC resources must be directed to properly house and care for this population but in the near future the IDOC must take the lead to create a pathway to discharge those men and women whose mental and medical conditions make them no longer a risk to society to appropriate settings in the community. This effort will need to include the judicial system, parole boards, influential advocacy groups, state legislatures, the governor's office, and other entities. It is also the monitor's position that the IDOC should not attempt to construct large long-length-of-stay skilled nursing or nursing home correctional facilities which would present notable difficulties to meet and maintain state certification standards.

The monitor will be asking the Plaintiffs' and the Defendants' legal counsel to modify three sections of the Consent Decree.

- 1) Provision III.M.2.b: "Federal Bureau of Prisons" should be replaced with "Center for Disease Control Adult Immunization Guidelines". The Federal Bureau of Prisons' (FBOP) immunization guidelines are generally aligned with the Center for Disease Control (CDC) guidelines but the FBOP policies are only changed at some length of time after the CDC updates its recommendations.
- 2) Provision III M. 2.c: The language on the Prostate Specific Antigen (PSA) testing is no longer consistent with the national guidelines and needs to be modified to be in alignment with the recommendations of the United States Preventive Services Task Force (USPSTF) which now recommends that men between the ages of 55 and 69 years be informed of the potential harms and benefits of the PSA testing and allowed to make an individual decision about their preference. Men should not be screened who do not express a preference for PSA screening. Give that national recommendations will invariably change as more research is performed, it

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Plaintiffs,	)	
	)	
v.	)	Case No. 13 C 1068
	)	
MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 8



ILLINOIS DEPARTMENT OF CORRECTIONS
DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

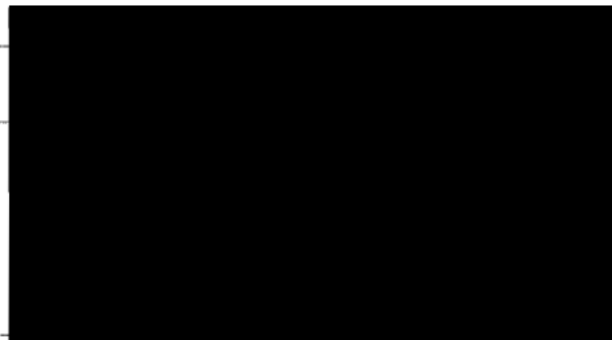
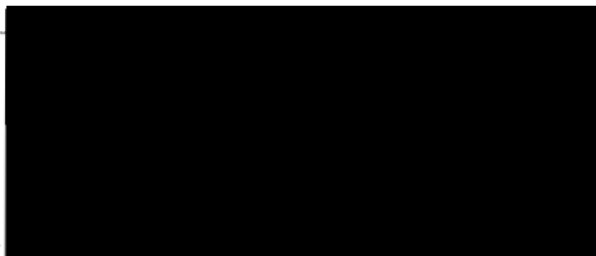
ROB JEFFREYS
Director

Please be aware that our medical and mental health staff are stretched thin and need to be focusing on our most vulnerable patients at this time. Please continue to utilize proper procedure for sick call and mental health evaluations.

To ensure your voice is being heard, we are instituting a virtual "suggestion box" via GTL, in addition to physical suggestion boxes at all facilities. We have also partnered with GTL to provide additional free services that will be announced at a later date.

Thank you for your cooperation as we work through this difficult situation together.

Alyssa Williams
Chief of Programs and Support Services





ILLINOIS DEPARTMENT OF CORRECTIONS
DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

ROB JEFFREYS
Director

Memorandum

To: Men and Women in Custody

From: Alyssa Williams, Chief of Programs and Support Services

Date: March 20, 2020

Subject: Administrative Quarantine

Dear Men and Women in the care of the Illinois Department of Corrections:

We are facing unprecedented circumstances across the United States and State of Illinois. Out of an abundance of caution, we are instituting an Administrative Quarantine effective immediately. Administrative Quarantine is an intentional form of restricted movement within a facility to accommodate for unusual needs or circumstances, such as a pandemic outbreak. This measure must be taken to ensure the health and safety of those who live and work in our facilities. We are asking for your assistance to minimize the difficulties you will face during this time.

We will continue to ensure you receive all necessary treatment and services, while finding creative ways to deliver programs vital to your success. We are working to minimize the impact on current Earned Program Sentence Credit contracts through alternative programming.

The Department will continue offering the following services:

- Showers
- Access to the phone and GTL kiosks
- Cleaning supplies
- Law Library
- Commissary

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MICHAEL STUDER, et al.,	)	
	)	
Defendants.	)	Hon. Robert M. Dow, Jr.

EXHIBIT 9
FILED UNDER SEAL

**IN THE UNITED STATES DISTRICT COURT FOR THE
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LESTER DOBBEY, on behalf of himself
and all others similarly situated,

Plaintiffs,

V.

MICHAEL STUDER, et al.,

Defendants.

Case No. 13 C 1068

Hon. Robert M. Dow, Jr.

EXHIBIT 10



4413 North Sheridan | Chicago, Illinois 60640
Phone: 773.769.1411 | Fax: 773.769.2224
www.uplcchicago.org

March 17, 2020

The Honorable J. B. Pritzker
207 State House
Springfield, IL 62706

Re: Coronavirus in Illinois Prisons

Dear Governor Pritzker:

The COVID-19 pandemic represents an unprecedented threat to men and women who are incarcerated in IDOC custody. These individuals are held in close quarters—several feet closer than the six-foot distance that you and the CDC have recommended for individuals not held in custody. They are simply not able to engage in the “social distancing” that public health officials have stressed is mandatory to combat the rate of illness. As a result, if any one of these individuals becomes infected with COVID-19, nearly everyone within the prison will face a dangerously high risk of becoming infected.

If and when (as is likely, given reports from countries like Italy who are experiencing our rate of infection just weeks ahead of the United States) IDOC prisons experience an outbreak, the prison’s health system will be overwhelmed. That, in turn, is likely to overwhelm local outside hospital systems where sick prisoners are referred, which will render them unable to provide lifesaving treatment to the population—both incarcerated and free—that need it.

We are thankful that at this point IDOC does not have any positive cases. To avoid contamination, in addition to the steps already announced by IDOC, it is imperative that you take action to ensure that every individual in IDOC custody today who can be released in a way that is consistent with public safety, is released.

This administration has taken the lead across the country in ensuring that the threat faced by the COVID-19 pandemic is taken seriously. In keeping with this administration’s initiative, we implore you to take the following immediate steps to protect the vulnerable individuals in IDOC custody, as well as the individuals who work there:

1. **Immediately order the release of individuals whose release dates are within 120 days.** These individuals have already worked with prison staff and those outside to confirm that they will be returning to a confirmed home site, and have release plans.

2. **Release all individuals in custody awaiting parole revocation hearings.** People previously on supervised release who are in IDOC custody because of non-violent parole violations and new charges that are bail eligible, and especially people in custody because of technical violations, should be released immediately.

3. **Prioritize release for any individuals whose release plans are pending host site approval.** These individuals have a place to return, but are simply waiting for IDOC to approve. These people should be prioritized, and once approved, immediately released.

4. **Order IDOC to stop taking people into custody for parole violations unless they present a clear and present danger of imminent physical harm, and rescind all parole warrants.** As we know from the information set out by your administration and the CDC, introducing new people into the prison population will only exacerbate the likelihood of an outbreak within the prison. IDOC should immediately stop taking any individuals into custody for parole or MSR violations unless their actions present a clear and present danger of imminent physical harm, and should withdraw all parole-related warrants.

5. **Release individuals with viable clemency petitions.** Several individuals have viable clemency petitions that are awaiting decision by this administration; anyone whose petitions are viable should be released immediately.

6. **Take all actions necessary to maximize good time credits.** Under Illinois law, 730 ILCS 5/3-6-3, the IDOC Director “may award up to 180 days of earned sentence credit for good conduct in specific instances as the Director deems proper.” This provision should be used proactively to reduce the population in IDOC facilities.

7. **Evaluate individuals who are pregnant, postpartum, or living with their infants in IDOC programs.** Pregnant and postpartum women, as well as the babies in the Moms and Babies nursery, are particularly vulnerable to illness. People who are pregnant often have suppressed immune systems and can also have decreased lung capacity, complicating respiratory illnesses. High fevers can also lead to birth defects and miscarriage. The majority of pregnant people and participants in the Moms and Babies program have release dates within the next twelve months. Their release should be prioritized through all available means.

8. **Evaluate individuals with HCU living assignments and chronic care needs for consideration of early release.** These are vulnerable populations who require significant staff time and resources. If these individuals have sentences that allow

for consideration of any form of early release, and home placement options, steps should be taken to get them released as soon as possible.

9. **Take steps to limit intake into IDOC facilities.** As we are quickly learning from public health experts, the safest way to protect against outbreaks of COVID-19 is to limit the number of social interactions. We urge you to take action to decrease the number of individuals being taken into IDOC custody, including by placing any limits allowable on receiving, by asking courts and prosecutors to adjust sentencing priorities to avoid incarceration to the fullest extent possible.

10. **Ensure that the IDOC has the resources necessary to combat a possible COVID-19 outbreak in one or more IDOC facilities.** It is imperative that IDOC have the resources that it needs to provide supplies to both prisoners and staff. This must include unfettered access to soap and cleaning supplies for prisoners, and thermometers and protective gear for staff.

These actions are a necessary first step to minimize the likelihood of an outbreak in IDOC facilities, and to contain the virus within the state. Many of the individuals in IDOC custody are among the most vulnerable for catastrophe should an outbreak occur. We hope that you will approach their health as seriously as you have approached the health of the rest of the state.

The organizations below would welcome an opportunity to speak with you or members of your administration about how to effectively respond to this public health emergency and protect the health and safety of individuals and IDOC custody and the Illinois community.

Signed,

ACLU of Illinois
Chicago Community Bond Fund
Chicago Urban League
Children and Family Justice Center, Bluhm Legal Clinic,
Northwestern Pritzker School of Law
Community Justice and Civil Rights Clinic, Bluhm Legal Clinic,
Northwestern Pritzker School of Law
Equip for Equality
John Howard Association
Legal Council for Health Justice
Loevy & Loevy
Roderick and Solange MacArthur Justice Center
Shriver Center on Poverty Law
Uptown People's Law Center
Women's Justice Institute

cc: Lt. Governor Juliana Stratton
Director Rob Jeffreys
Chief of Staff Camile Lindsay
Gary Caplan, Office of the Governor
Christian Mitchell, Deputy Governor for Public Safety, Infrastructure, Energy &
Environment

**IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION**

LESTER DOBBEY, on behalf of himself
and all others similarly situated,

Plaintiffs,

v.

MICHAEL STUDER, et al.,

Defendants.

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Case No. 13 C 1068

Hon. Robert M. Dow, Jr.

EXHIBIT 11
FILED UNDER SEAL

**IN THE UNITED STATES DISTRICT COURT FOR THE
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LESTER DOBBEY, on behalf of himself
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Case No. 13 C 1068

Hon. Robert M. Dow, Jr.

EXHIBIT 12
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**IN THE UNITED STATES DISTRICT COURT FOR THE
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EXHIBIT 13

Public Health Officials Announce 461 New Cases of Coronavirus Disease

 dph.illinois.gov/news/public-health-officials-announce-461-new-cases-coronavirus-disease

SPRINGFIELD – The Illinois Department of Public Health (IDPH) today reported 461 new cases of coronavirus disease (COVID-19) in Illinois. Eight new deaths are also being reported, including the death of an incarcerated man from Stateville Correctional Center.

- Cook County: male 50s, male 60s, female 60s, female 70s
- DuPage County: male 60s
- Kendall County: female 60s
- Will County: male 50s, male 60s

Additionally, 12 men who were incarcerated at Stateville are now hospitalized, including several requiring ventilators. There are 77 more incarcerated individuals with symptoms who are isolated at the facility. Eleven staff are also being isolated.

The Illinois Department of Corrections is taking a number of steps to control the spread of COVID-19 in its correctional centers. Staff who work with individuals in isolation and quarantine, as well as in the health center, are wearing full personal protective equipment (PPE) and all staff are wearing some PPE. Staff are also having their temperature checked daily as they enter the facility.

Correctional centers with a confirmed case are placed on lockdown, which means there is no movement around the facility except for medical care. Incarcerated individuals who show symptoms are being tested.

Clark, Crawford, Marion, Randolph, and Saline counties are now reporting cases. Currently, IDPH is reporting a total of 5,057 cases, including 73 deaths, in 52 counties in Illinois. The age of cases ranges from younger than one to 99 years.

For all personal protective equipment (PPE) donations, email PPE.donations@illinois.gov. For health questions about COVID-19, call the hotline at 1-800-889-3931 or email dph.sick@illinois.gov. Medically trained professionals able to volunteer are asked to sign up at www.illinoishelps.net.

*All data are provisional and will change.