IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MICHAEL GRAHAM; ALEXUS DIGGS; and HEATHER CONNOLLY, on behalf of themselves and all others similarly situated,	:	**Case No.** 20-496
Plaintiffs-Petitioners,	:	
v.	:	**ELECTRONICALLY FILED**
ALLEGHENY COUNTY; ORLANDO HARPER, Warden of Allegheny County Jail,	:	**IMMEDIATE RELIEF SOUGHT**
Defendants-Respondents.	:	

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

INTRODUCTION

1. Petitioner-Plaintiffs are three individuals held at Allegheny County Jail ("ACJ") who have a serious pre-existing medical condition which the United States Centers for Disease Control has determined puts them at significantly higher risk of severe disease and death if they contract COVID-19. They claim that the conditions of confinement now existing at ACJ create a heightened and unreasonable risk of contracting COVID-19 for any person confined at the jail and a substantial risk of severe illness or death for those who are elderly and/or medically vulnerable to COVID-19. They bring this class action claim seeking immediate release of all individuals 55 and older and those with medical conditions that place them at heightened risk of severe illness or death from COVID-19, which would both remove these individuals from a life threatening situation at the jail and permit social distancing measures recommended by the Centers for Disease Control (CDC) and other public health officials to be implemented for those remaining at the jail. Plaintiffs also seek injunctive relief to require Defendants to comply with recommended safety and health measures to prevent the spread of the virus for those confined at the jail, which they are unconscionably not now implementing. For example, Defendant Harper blatantly disregarded those recommendations when, after the release of 600 people from the jail, has closed an entire floor of ACJ, consolidating, rather than distancing, the remaining population at ACJ.

2. Prisons and jails are quickly becoming the epicenter of COVID-19 in cities throughout the country, including New York, Chicago and Philadelphia. ACJ is poised to join these ignoble ranks due to the congregate nature of jails, exacerbated by ACJ's unnecessary crowding, inadequate sanitation, denial of hygiene products and non-existent quarantine procedures. The current conditions at ACJ create an extreme risk for rapid, uncontrollable spread

of COVID-19 throughout the facility with grave outcomes for both the incarcerated population and the surrounding communities.

3. A substantial number of people currently held at ACJ face serious risks of life-threatening injury due to their age and/or underlying medical conditions. Issuing a writ of habeas corpus, a foundational element of the constitutional order, is both a proper and essential action to prevent unnecessary loss of life.

4. For those who remain incarcerated at ACJ, conditions must be substantially altered to accord with the Centers for Disease Control (CDC) recommendations for social distancing and enhanced sanitation and hygiene practices. Defendants must immediately be enjoined to eliminate double-celling; provide adequate hygiene supplies; ensure that increased sanitation practices conform to CDC standards; conduct recreation and meal service in a manner that allows for appropriate social distancing; and require the use of Personal Protective Equipment (PPE) for staff and all incarcerated people.

5. Accordingly, Petitioners/Plaintiffs, on behalf of classes of persons incarcerated at the ACJ, bring this action and request immediate release of all Petitioners/Plaintiffs and medically vulnerable individuals, coupled with appropriate support and conditions upon release, as informed by public health expertise. If this Court does not grant immediate release on the basis of this Petition-Complaint, Petitioners/Plaintiffs request a hearing as soon as possible. Given the exponential spread of COVID-19, there is no time to spare.

I. JURISDICTION AND VENUE

6. Petitioners/Plaintiffs bring this putative class action pursuant to 22 U.S.C. § 2241, 42 U.S.C. § 1983, 28 U.S.C. §§ 2201, 2202, and the Americans with Disabilities Act, 42 U.S.C.

§§ 12101 et seq. ("ADA"), for relief from both detention and conditions of confinement that violate their Fourteenth Amendment rights under the U.S. Constitution.

7. This Court has subject matter jurisdiction over these claims pursuant to 28 U.S.C. § 2241 (habeas corpus), 28 U.S.C. § 1651 (All Writs Act), Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause), 28 U.S.C. § 1343(a) (civil rights jurisdiction), and 28 U.S.C. § 1331 (federal question jurisdiction).

8. This Court is the appropriate venue pursuant to 28 U.S.C. § 1391(b)(2) because the events and omissions giving rise to the claims occurred in the Western District of Pennsylvania.

II. PARTIES

9. Plaintiff Michael Graham is a 38-year-old man currently held as a pretrial detainee at ACJ on a probation detainer and non-violent criminal charges. Mr. Graham has been diagnosed with asthma and hepatitis C, conditions that have substantially limited his respiratory and digestive systems, making him a qualified individual with a disability under the ADA. His underlying health conditions place him at high risk of severe illness or death if he contracts COVID-19.[1]

10. Plaintiff Alexus Diggs is a 24-year-old woman currently held as a pretrial detainee at ACJ on a probation detainer and a misdemeanor charge. Ms. Diggs has been diagnosed with hypertension, a condition that has substantially limited her circulatory system, making her a qualified individual with a disability under the ADA. Her underlying health conditions place her at increased risk of severe illness or death if she contracts COVID-19.[2]

---

[1] Exhibit A, Expert Declaration of Dr. Joseph Amon, Ph.D. MSPH, ¶ 15. Dr. Amon is an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health with past experience as an epidemiologist in the Epidemic Intelligence Service of the U.S. Center for Disease Control and Prevention.

[2] *Id.* at ¶ 12.

11. Plaintiff Heather Connolly is a 49-year-old woman currently held as a pretrial detainee at ACJ on a probation detainer and additional non-violent misdemeanor and summary charges. Ms. Connolly has been diagnosed with hepatitis C, a condition that has substantially limited her digestive system, making her a qualified individual with a disability under the ADA. Her underlying health conditions place her at high risk of severe illness or death if she contracts COVID-19.[3]

12. Defendant Allegheny County is a county government organized and existing under the laws of the Commonwealth of Pennsylvania. Allegheny County controls and operates ACJ through Defendant Warden Orlando Harper. Allegheny County currently has immediate custody over Plaintiffs Graham, Diggs, and Connolly and all other putative class members.

13. Defendant Orlando Harper is the Warden at ACJ. Defendant Harper currently has immediate custody over Plaintiffs Graham, Diggs, and Connolly and all other putative class members. Defendant Harper is a policymaker for Allegheny County. Defendant Harper is sued in his official capacity.

III. FACTUAL ALLEGATIONS

A. COVID-19 Poses a Significant Risk of Illness, Injury, and Death

14. We are in the midst of the most significant pandemic in generations.[4] The lethality rate of Coronavirus Disease 19 ("COVID-19"), the serious respiratory disease caused by this

---

[3] *Id.* at ¶ 11.

[4] John M. Barry, *The Single Most Important Lesson from the 1918 Influenza*, New York Times (March 17, 2020), https://cutt.ly/PtQ5uAZ (Opinion piece by author of "The Great Influenza: The Story of the Deadliest Pandemic in History," noting comparison between current COVID-19 outbreak and the 1918 influenza outbreak widely considered one of the worst pandemics in

coronavirus, is estimated to be between 1 and 6%: about tenfold higher than that observed from a severe seasonal influenza that kills thousands a year.[5] As of 12 p.m. on April 5, 2020, there were 11,510 confirmed cases of COVID-19 in Pennsylvania and 150 deaths.[6] In Allegheny County, there were 642 cases and 4 deaths as of April 6, 2020.[7] These numbers likely underestimate the impact and spread of the virus, given the lack of testing.[8] The virus is spreading exponentially.[9] In fact, the number of confirmed COVID-19 cases in Allegheny County jumped 16% just between April 3 and April 4, 2020.[10] Without effective public health interventions, CDC projections

---

history). [5] As of April 6, 2020, there were 1,289,380 confirmed cases globally, with 70,590 deaths and 270,372 recoveries. Johns Hopkins University of Medicine, *Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering at Johns Hopkins University*, https://cutt.ly/StEyn2U.; Exhibit A, Expert Declaration of Dr. Jonathan Louis Golob, M.D., ¶4. Dr. Golob is an Assistant Professor at the University of Michigan School of Medicine in Ann

[5] As of April 6, 2020, there were 1,289,380 confirmed cases globally, with 70,590 deaths and 270,372 recoveries. Johns Hopkins University of Medicine, *Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering at Johns Hopkins University*, https://cutt.ly/StEyn2U.; Exhibit A, Expert Declaration of Dr. Jonathan Louis Golob, M.D., ¶4. Dr. Golob is an Assistant Professor at the University of Michigan School of Medicine in Ann
Arbor, Michigan, and a specialist in infectious diseases and internal medicine with a subspeciality in infections in immunocompromised patients. [6] Amon Decl. ¶ 5. [7] https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx.

[6] Amon Decl. ¶ 5. [7] https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx.

[7] https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx.

[8] Amon Decl. ¶ 5.

[9] *See* Golob Decl. ¶ 2; Amon Decl. ¶ 5 ("There has been an exponential increase in cases and deaths in Pennsylvania over the past three weeks with the number of people infected increasing, on average by 32% every day.")[10] Paul Peirce, *Allegheny County reports 3rd covid-19 death, 16% jump in confirmed coronavirus cases in one day*, Trib Live (April 4, 2020), https://triblive.com/local/pittsburgh-allegheny/allegheny-county-reports-third-covid-19-death-16-jump-in-confirmed-coronavirus-cases-in-one-day/[11] Golob Decl. ¶ 11.

[10] Paul Peirce, *Allegheny County reports 3rd covid-19 death, 16% jump in confirmed coronavirus cases in one day*, Trib Live (April 4, 2020), https://triblive.com/local/pittsburgh-allegheny/allegheny-county-reports-third-covid-19-death-16-jump-in-confirmed-coronavirus-cases-in-one-day/[11] Golob Decl. ¶ 11.

indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections.[11]

15. The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.[12] There is no vaccine against COVID-19, and there is no known medication to prevent or treat infection.[13] Social distancing—deliberately keeping at least six feet of space between persons to avoid spreading illness[14]—and a vigilant hygiene regimen, including washing hands frequently and thoroughly with soap and water, are the only known measures for protecting against transmission of COVID-19.[15] Because the coronavirus spreads among people who do not show symptoms, staying away from people is the best way to prevent infection.[16] In other words, *everyone*—including the staff at ACJ—has to act as if *everyone* has the disease.

16. COVID-19 can cause severe damage to lung tissue, including a permanent loss of respiratory capacity, and it can damage tissues in other vital organs, such as the heart and liver.[17]

17. People over the age of fifty face a greater risk of serious illness or death from COVID-19.[18] In a February 29, 2020 preliminary report, individuals age 50-59 had an overall

---

[11] Golob Decl. ¶ 11.
[12] Amon Decl. ¶ 16
[13] *Id.* at ¶6; Golob Decl. ¶ 10.
[14]Golob Decl. ¶10.
[15] *Id.*
[16] Amon Decl. ¶ 18.
[17] Golob Decl. ¶9.
[18] Golob Decl. ¶14; *see also* Amon Decl. ¶ 9 (observing that "those ≥54 years could be considered high risk for severe disease and death."

mortality rate of 1.3%; 60-69-year-olds had an overall 3.6% mortality rate, and those 70-79 years old had an 8% mortality rate.[19]

18. People of any age are also at an elevated risk if they 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 disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, or asthma.[20] An early report from the World Health Organization ("WHO") estimated the mortality rate of 13.2% for COVID-19 patients with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[21]

19. In many people, COVID-19 causes fever, cough, and shortness of breath.[22] Most people in higher risk categories who develop serious illness will need advanced support.[23] This requires highly specialized equipment like ventilators that are in limited supply, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians.[24]

20. The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 infection than from influenza.[25] According to recent estimates, the fatality

---

[19] *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths* Chart, https://cutt.ly/ytEimUQ (data analysis based on WHO China Joint Mission Report).
[20] Amon Decl. ¶8; Golob Decl. ¶3, 14.
[21] *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), at 12, https://cutt.ly/xtEokCt.
[22] Golob Decl. ¶5.
[23] *Id.* at ¶8.
[24] *Id.*
[25] *Id.* at ¶ 4.

rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.[26] For people in the highest risk populations, the fatality rate of COVID-19 infection is about 15 percent.[27] Patients who do not die from serious cases of COVID-19 may face prolonged recovery periods, including extensive rehabilitation from neurologic damage, loss of digits, and loss of respiratory capacity.[28]

B. **The Release of Medically Vulnerable People is Necessary to Reduce the Grave and Immediate Danger that COVID-19 Will Result in Serious Harm or Death at ACJ**

21. People in congregate environments—places where people live, eat, and sleep in close proximity—face increased danger of coronavirus infection and COVID-19, as already evidenced by the rapid spread of the virus in cruise ships and nursing homes.[29] It is virtually impossible for people who are confined in prisons, jails, and detention centers as presently constituted and run to engage in the necessary social distancing and hygiene required to mitigate the risk of transmission of the disease.[30]

22. Correctional settings further increase the risk of contracting COVID-19 because of the concentration of people with chronic, often untreated, illnesses in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, presence of many high-contact surfaces, and no possibility of staying at a distance from others.[31]

23. Jails have generally proven to be incapable of implementing CDC recommendations, and incarcerated people are already dying nationwide as a result, including

---

[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.* at ¶ 12; Amon Decl. ¶ 23.
[30] *See* Amon Decl. at ¶ 23; Golob Decl. ¶ 13.
[31] Amon Decl. ¶¶ 22-23, 26, 40;

eight deaths of individuals incarcerated at two federal Bureau of Prisons facilities.[32] This is demonstrated by dramatic outbreaks in the Cook County Jail and Rikers Island in New York City, where the transmission rate for COVID-19 is estimated to be the highest in the world.[33]

24. Outbreaks of the flu regularly occur in jails; during the H1N1 epidemic in 2009, jails and prisons dealt with a disproportionately high number of cases.[34]

25. Numerous public health experts, including Dr. Amon[35], Dr. Golob[36], Dr. Gregg Gonsalves,[37] Ross MacDonald,[38] Dr. Marc Stern,[39] Dr. Oluwadamilola T. Oladeru and Adam Beckman,[40] Dr. Anne Spaulding,[41] Homer Venters,[42] the faculty at Johns Hopkins schools of

---

[32] *See* Amon Decl. ¶ 31, 33; *COVID-19 Coronovirus*, Federal Bureau of Prisons, https://cutt.ly/itRSDNH; *see also, e.g.*, Lara Salahi, *2nd Mass. Inmate Dies of Coronavirus*, NBC Boston (April 5, 2020); Josiah Bates, *New York's Rikers Island Jail Sees First Inmate Death From COVID-19*, Time (April 6, 2020); Megan Crepeau and Jason Meisner, *Cook County Jail detainee dies of COVID-19*, Chicago Tribune (April 7, 2020 6:30 a.m.).[33] Amon Decl. ¶ 31; Golob Decl. ¶ 12.

[33] Amon Decl. ¶ 31; Golob Decl. ¶ 12.

[34] *See, e.g.,* Golob Decl., ¶ 13. This H1N1 "swine flu" pandemic outbreak spread dramatically in jails and prisons in 2010, but that strain of virus had a low fatality rate because of the characteristics of the virus—COVID-19's fatality rate is far higher. *See* David M. Reutter*, Swine Flu Widespread in Prisons and Jails, but Deaths are Few* (Feb. 15, 2010), https://cutt.ly/ytRSkuX.

[35] Amon Decl. ¶¶ 22-23, 34, 46.

[36] Golob Decl. ¶¶ 13-14.

[37] Kelan Lyons, *Elderly Prison Population Vulnerable to Potential Coronavirus Outbreak,* Connecticut Mirror (March 11, 2020), https://cutt.ly/BtRSxCF.

[38]Craig McCarthy and Natalie Musumeci, *Top Rikers Doctor: Coronavirus 'Storm is Coming,'* New York Post (March 19, 2020), https://cutt.ly/ptRSnVo.

[39] Marc F. Stern, MD, MPH, *Washington State Jails Coronavirus Management Suggestions in 3 "Buckets,"* Washington Assoc. of Sheriffs & Police Chiefs (March 5, 2020), https://cutt.ly/EtRSm4R.

[40] Oluwadamilola T. Oladeru, et al., *What COVID-19 Means for America's Incarcerated Population – and How to Ensure It's Not Left Behind*, (March 10, 2020), https://cutt.ly/QtRSYNA.

[41] Anne C. Spaulding, MD MPDH, *Coronavirus COVID-19 and the Correctional Jail,* Emory Center for the Health of Incarcerated Persons (March 9, 2020).

[42] Madison Pauly, *To Arrest the Spread of Coronavirus, Arrest Fewer People*, Mother Jones (March 12, 2020), https://cutt.ly/jtRSPnk.

nursing, medicine, and public health,[43] and Josiah Rich[44] have all strongly cautioned that people booked into and held in jails are likely to face serious, even grave, harm due to the outbreak of COVID-19.

26. The only viable strategy to combat the spread of COVID-19 and prevent serious harm or death to class members is risk mitigation.[45] Even with the most comprehensive plan to address the spread of COVID-19 in detention facilities, the release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is a key part of a risk mitigation strategy.[46] Immediate release of the medically vulnerable population not only protects them from transmission of COVID-19, but also allows for greater risk mitigation for people held or working in the jail and the broader community.[47]

27. Release of the most vulnerable people from custody also reduces the burden on the region's health care infrastructure by reducing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.[48]

---

[43] Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Maryland, March 25, 2020, https://cutt.ly/stERiXk.

[44] Amanda Holpuch, *Calls Mount to Free Low-risk US Inmates to Curb Coronavirus Impact on Prisons*, The Guardian (March 13, 2020 3:00 p.m.), https://cutt.ly/itRSDNH.

[45] *See* Amon Decl. ¶ 43.

[46] *Id*.

[47] *See id.* at ¶ 46.

[48] *See id.* at ¶ 41; This is especially important in Allegheny County as the county is already projected to face an unprecedented shortage of hospital beds in intensive care units. Krirs B. Maula and Anya Litvak, *Study: Pittsburgh region has far fewer hospital beds than needed for moderate COVID-19 outbreak* Pittsburgh Post-Gazette (March 22, 2020 6:00 a.m.) https://www.post-gazette.com/business/healthcare-business/2020/03/22/harvard-global-health-institute-univeristy-Pittsburgh-COVID-19-outbreak-hospital-beds/stories/202003180109.

28. In the United States, jail administrators in Cuyahoga County, Ohio[49]; Los Angeles, California[50]; San Francisco, California[51]; Jefferson County, Colorado[52]; Montgomery, Alabama[53]; and the State of New Jersey,[54] among others, have concluded that widespread jail release is a necessary and appropriate public health intervention.

29. Notwithstanding a population reduction of approximately 600 people in the last month from ACJ and the limited measures that Allegheny County has taken to prevent the introduction of COVID-19, immediate release of the medically vulnerable population remains a necessary public health intervention.[55] Petitioners/Plaintiffs are at an increased risk of developing serious complications from coronavirus infection and COVID-19 due to their underlying medical conditions.[56] Release is needed not only to prevent irreparable harm to members of the medically vulnerable subclass, but also to reduce the incarcerated population at ACJ sufficiently to ensure proper social distancing, which will reduce the likelihood of infection for all class members and the wider public.[57]

---

[49] Scott Noll, *Cuyahoga County Jail Releases Hundreds of Low-Level Offenders to Prepare for Coronavirus Pandemic*, (March 20 2020 6:04 p.m.), https://cutt.ly/CtRSHkZ.
[50] Alene Tchekmedyian, *More L.A. County Jail Inmates Released Over Fears of Coronavirus Outbreak,* L.A. Times, (March 19, 2020 6:55 p.m.), https://cutt.ly/ltRSCs6.
[51] Megan Cassidy, *Alameda County Releases 250 Jail Inmates Amid Coronavirus Concerns, SF to Release 26,* San Francisco Chronicle (March 20, 2020), https://cutt.ly/0tRSVmG.
[52] Jenna Carroll, *Inmates Being Released Early From JeffCo Detention Facility Amid Coronavirus Concerns*, KDVR Colorado (March 19, 2020 2:29 pm.), https://cutt.ly/UtRS8LE.
[53] *See In Re: COVID-19 Pandemic Emergency Response,* Administrative Order No. 4, Montgomery County Circuit Court (March 17, 2020).
[54] Erin Vogt, *Here's NJ's Plan for Releasing Up to 1,000 Inmates as COVID-19 Spreads* (March 23, 2020), https://cutt.ly/QtRS53w.
[55] *See* Amon Decl. ¶ 43.
[56] *Id*. at ¶¶ 10-15.
[57] *Id* at ¶ 45 ("Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees[.]"). Further, in the prison context, the American Bar Association (ABA) urges that, "Governmental authorities in all branches in a jurisdiction should

C. The Current Conditions of Confinement at ACJ Exacerbate the Extreme and Imminent Danger Faced by Class Members of Contracting and Possibly Dying from COVID-19

30. Even in the best of times, ACJ, like many urban detention facilities, is beset with health problems and staffing challenges. Ominously, however, officials there have exacerbated and increased the risks to the health and life of class members during the current pandemic by maintaining unconstitutional conditions of confinement that will increase the risk of class members contracting COVID-19.

31. More than 600 detainees have been released from the Allegheny County Jail over the past month in recognition that coronavirus and COVID-19 pose significant risks in a jail. But Defendants-Respondents have not taken advantage of that release to implement social distancing recommendations to keep detainees at least six feet apart. Remarkably, they have done just the opposite. Failing to heed the unanimous recommendations of public health experts, Defendants-Respondents have actually consolidated the remaining incarcerated population by moving them closer together.[58]

32. Defendants-Respondents are placing two detainees to a cell, even though empty cells remain on the open floors.

33. Defendants-Respondents have shuttered two entire floors of the jail instead of using the cells on those floor to single cell prisoners and keep them a safe distance apart.[59]

---

take necessary steps to avoid crowding that… adversely affects the … protection of prisoners from harm, including the spread of disease." ABA Standard on Treatment of Prisoners 23-3.1(b).

[58] Bob Mayo, *First on 4: 1500 Allegheny County Jail Inmates not being spread out, despite release of 700* (Apr 2, 2020), https://www.wtae.com/article/first-on-4-1500-allegheny-county-jail-inmates-not-being-spread-out-despite-release-of-700/32018165# (quoting email from Defendant Harper noting that first floor had been closed "late last week").

[59] The seventh floor housing pods have not been in use since prior to the emergence of the COVID-19 threat.

34. On information and belief, Defendants-Respondents have reduced staffing levels at ACJ as a result of the population decrease.

35. The actions of Defendants-Respondents are undermining one of the primary purposes of the county courts' release efforts, namely, to open up space inside the jail to enable safe social distancing.

36. On information and belief, at this time, the majority of occupied cells at ACJ currently house two people, even though empty cells remain available, both on currently open pods as well as on the pods ACJ recently closed.[60]

37. The cells at ACJ are not big enough to allow cellmates to stay six feet apart. The beds are bunk-style, and the remainder of the cell contains a desk, toilet, and a sink.[61]

38. Meals are distributed on the pod and eaten at tables in the dayroom. Up to 100 people may be on the pod during meals. Even on those pods where only half of the population is released for meals at one time, there are typically 40-50 people out together. The tables on the pod are small, approximately 4 square feet, which means people are forced to eat more closely together than recommended.[62]

39. Likewise, up to 100 people recreate together, many in close contact. Group recreation is continuing. Some pods very recently began to split recreation, but even that measure leaves 40-50 people in close contact and not able to the maintain six-foot distance between them.[63]

---

[60] *See* Exhibit C, Declaration of Alexus Diggs, at ¶¶ 4, 15; Exhibit D, Declaration of Heather Connolly at ¶¶ 5, 14, 17; Exhibit E, Declaration of Larnell Jones, at ¶ 9; Exhibit F, Declaration of Michael Graham, at ¶¶ 16-17; Exhibit G, Declaration of Terry Suggs at ¶¶ 8, 10.
[61] Connolly Decl. ¶ 6; Suggs Decl. ¶ 9.
[62] Suggs Decl. ¶¶ 11, 13; Jones Decl. ¶¶ 11, 13; Graham Decl. ¶¶ 14-15; Amon Decl. ¶26.
[63] Suggs Decl. ¶¶ 11-12; Jones Decl. ¶¶ 11-12; Graham Decl. ¶ 15.

40. People are also crowded together at the communal phones, standing elbow-to-elbow with others when making calls. As visitation has been suspended, these phone calls are the only means remaining for individuals to communicate quickly with their worried families. Phones are not being disinfected or in any way sanitized between the calls.[64]

41. Showers are shared by people housed on the unit, and they are not disinfected between uses, increasing the chances of transmission.[65]

42. There is currently no COVID-19 testing performed on ACJ employees.[66] This presents a daily risk of introduction of coronavirus into ACJ. Upon information and belief, ACJ is taking staff members' temperature upon their entrance to the jail, but the possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate to identify all who may be infected and thereby reduce the risk of transmission.[67] This is also true because not all individuals infected with COVID-19 present with fever in early stages of infection.[68]

43. The lack of proven cases of COVID-19 where there is little to no testing is functionally meaningless to determine if there is a risk for COVID-19 transmission both in the jail and in the community. In other jurisdictions where testing has been made available to correctional

---

[64] Suggs Decl. ¶ 16; Jones Decl. ¶ 16-18; Graham Decl. ¶ 15.
[65] Connolly, Decl. ¶ 20; Suggs Decl. ¶ 17; Jones Decl. ¶ 1; Graham Decl. ¶ 17; Diggs Decl. ¶ 18.
[66] Exhibit H, Allegheny County Jail, Continuing of Operations Plan: COVID-19 (Updated), March 30, 2020, at 3-4 (describing employee screening involving temperature taking and questions, then noting that for employees who cannot work with a fever, "Testing can also be arranged through the Allegheny County Health Department.")
[67] Amon Decl. ¶ 29.
[68] *Id.* ("The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate for identifying all who may be infected and preventing transmission.").

officers who enter and leave facilities regularly, the rates of infection are high.[69] These officers are further vectors of the virus: like detainees, they may be asymptomatic while still contagious.

44. At least one corrections officer has tested positive for COVID-19 and several others have been isolated as a result.[70] On information and belief, ACJ has made absolutely no effort to identify, notify, or isolate incarcerated detainees who may also have come in contact with any of those corrections officers.

45. On information and belief, corrections officers who are exhibiting respiratory symptoms and fever are still interacting with and escorting incarcerated people in the jail.

46. ACJ's existing intake and isolation procedures are grossly inadequate to prevent COVID-19 in the facility.[71] For example, a 57-year-old man who was recently admitted to the jail spent only four days in intake before placement in a general housing pod with a medically vulnerable cellmate.[72]

47. ACJ staff also have not provided basic but critical information or education to the incarcerated population about COVID-19.[73] Indeed, no staff even informed the incarcerated population about COVID-19 until March 31st or April 1st.[74] These belated communications did not include any medical information for the population about COVID-19, its symptoms, the reason for social distancing (or even what the term means), the need to increase personal hygiene, the fact

---

[69] Amon Decl. ¶¶ 31-33.
[70] Paula Reed Ward, *Jail employee tests positive for COVID-19*, Pittsburgh Post-Gazette (March 28, 2020 9:06 a.m.) https://www.post-gazette.com/news/crime-courts/2020/03/28/Jail-employee-tests-positive-for-COVID-19/stories/202003280036.
[71] *See* Exhibit H at 4-5; Amon Decl. ¶¶ 29-30.
[72] Suggs Decl. ¶ 8.
[73] Diggs Decl. ¶7; Connoly Decl. ¶ 16; Jones Decl. ¶¶ 14-15; Graham Decl. ¶8; Suggs Decl. ¶¶ 14-15.
[74] Diggs Decl. ¶¶ 7-13.

that people can be asymptomatic carriers, or the importance of reporting symptoms consistent with COVID-19 as soon as they are experienced.[75]

48. In fact, Plaintiffs Diggs and Connolly had not heard the term "social distancing" before speaking with counsel on Saturday, March 28.[76]

49. As of April 1, reports emerged that some staff finally began to order incarcerated people to maintain a six-foot distance from each other or staff.[77]

50. On April 1, Defendant Harper came onto pod 4F and personally ordered everybody to stand six-feet apart or else they would all be locked down.[78] He was questioned about double-celling and group recreation and meals but only responded by saying he will not discuss "technicalities."[79]

51. Neither the detainees nor staff are required to wear masks. Upon information and belief, not all detainees have been provided with masks, and those detainees who have been issued masks have not been instructed on their effective and adequate use.[80] Defendants-Respondents did not provide staff or incarcerated people with any personal protective equipment (PPE), including masks, until Saturday, April 4.[81] Staff passed out these masks with bare hands and did not provide people with instructions on how to put them on and remove them, or use them effectively.[82] Detainees are not required to wear masks, and neither are staff.[83]

---

[75] *Id.*
[76] *Id.* at ¶ 7; Connolly Decl. ¶ 16.
[77] *See e.g.,* Diggs Decl. ¶¶ 9-13.
[78] *Id.*
[79] *Id*.
[80] Id.
[81] Connolly Decl. ¶ 18; Graham Decl. ¶ 18.
[82] Connolly Decl. ¶ 18; Graham Decl. ¶ 18.
[83] *Id.*

52. On information and belief, staff have previously been specifically instructed NOT to wear masks within the facility, to avoid causing concern in the incarcerated population. At least one corrections officers was recently disciplined by Defendant Harper for refusal to conduct searches of cells without a mask.

53. Defendants-Respondents permits detainees access to only one bar of soap and one roll of toilet paper per week.[84] This rationing has been inadequate to meet peoples' needs.[85] For example, Plaintiff Graham has been without a bar of soap since April 1st, and another detainee reported that a fight broke out in his housing pod over limited toilet paper after somebody had run out.[86]

54. Further, Defendants-Respondents have not consistently or effectively increased sanitation measures at ACJ since the onset of COVID-19, with people reporting that cleaning of common areas depends on the staff on duty, as not all staff carry out enhanced cleaning measures.[87]

55. Incarcerated people are denied access to cleaning supplies for their own cells.[88] Cleaning is supposed to happen weekly, but this does not regularly occur.[89]

56. ACJ medical services are woefully inadequate to address a significant COVID-19 outbreak at the jail. As of February 26, 2020, the jail had 48 health care vacancies out of an expected health care staff of approximately 136 full and part-time positions.[90] That means around

---

[84] Diggs. Decl. ¶ 14 (noting that staff recently confiscated second rolls of toilet paper); Graham Decl. ¶ 16; Suggs Decl. ¶ 20.
[85] Diggs. Decl. ¶ 14 (ran out of toilet paper); Graham Decl. ¶16 (ran out of soap); Suggs Decl. ¶ 22 ("People have run out of toilet paper in the middle of the week and have taken to using request forms to wipe themselves.").
[86] Graham Decl. ¶ 16; Suggs Decl. ¶¶ 20-22.
[87] Connolly Decl.¶ 21; Diggs Decl. ¶ 19; Graham Decl. ¶ 19.
[88] Diggs Decl. ¶ 17; Connolly Decl. ¶ 19; Jones ¶ 20; Graham Decl. ¶19; Suggs Decl. ¶ 18.
[89] Suggs Decl. ¶18.
[90] Exhibit I, ACJ Employees List & ACJ Health Vacancies.

one-third of all health care positions at the jail are vacant, though the situation may be even worse due to the substantial number of leadership and full-time positions that are vacant. These vacancies include the Health Services Administrator, the Director of Nursing, 6 full time Licensed Practical Nurses (LPN); 2 part-time LPNs; 4 full-time Medical Assistants; 3 part-time Medical Assistants; 6 full-time Registered Nurses; 8 part-time Registered Nurses; 2 full-time Assistant Directors of Nursing; 2 full-time Administrative Assistants.[91] This shortage of medical staff results in often delayed medical care at the jail.[92]

57. Even prior to the pandemic, delayed and denied medical care was a chronic problem at ACJ. These systemic failings are only worsened by the extensive care required by COVID-19.

58. Defendants-Respondents fail to adequately treat and quarantine individuals presenting with COVID-19 symptoms.[93] Individuals report remaining in their cells, with cellmates, receiving infrequent visits and temperature checks from healthcare staff.[94]

59. For example, Plaintiff Connolly began feeling ill in mid-March and felt slightly feverish for 7-10 days.[95]

---

[91] *Id*.
[92] Health care staffing assessment based on data obtained from the Jail Oversight Board on vacancies and current employees and attached as Ex. H.
[93] Ex. H at 11 ("Individuals will remain locked in their cells and separated from the general population…. If an individual is diagnosed with COVID-19, medication pass will be conducted at their cell door." and noting that inmate will be provided with a mask only when they are sick enough to require transport to a hospital.); *see* Amon Decl. ¶35 ("In cases where there are confirmed or suspected cases of COVID-19, the CDC recommends medical isolation, defined by the CDC confining the case "ideally to a single cell with solid walls and a solid door that closes" to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space."); ¶¶ 37-38 (noting that incarcerated people should wear face masks "at all times" when in close contact of suspected cases).
[94] *See* Connolly Decl. ¶¶ 4-9.
[95] *Id*. at ¶ 4.

60. Nonetheless, she only had her temperature taken once during this time, on March 22, when she was found to have a slightly elevated fever. She was subsequently locked in her cell, with her cellmate, for three days.[96]

61. While locked in her cell she never again had her temperature taken, although she continued to feel feverish.[97]

62. During this time Ms. Connolly felt other adverse health symptoms, including shortness of breath, nausea resulting in vomiting, and loss of appetite.[98]

63. Ms. Connolly was never taken to the infirmary, or otherwise provided any medical care.[99]

64. Ms. Connolly also reported that her cellmate had a high fever and was suffering extreme shortness of breath. Her cellmate was eventually taken to the infirmary.[100]

65. No further precautions were taken for those confined on her pod or who otherwise had interaction with either Ms. Connolly or her cellmate.[101]

66. Another person was moved into Ms. Connolly's cell shortly after her cellmate was taken to the infirmary. Her new cellmate has a colostomy bag and serious medical conditions.[102]

---

[96] *Id*. at ¶ 5.
[97] *Id*. at ¶ 7.
[98] *Id*. at ¶ 8. According to a study published in *The American Journal of Gastroenterology*, digestive symptoms, including vomiting and loss of appetite appeared in slightly more than 50% of a cohort of 204 patients diagnosed with Covid-19. *See* "Covid-19: 'digestive symptoms are common', Maria Cohut, March 20, 2020, https://www.medicalnewstoday.com/articles/covid-19-digestive-symptoms-are-common.
[99] Connolly Decl. ¶ 9.
[100] *Id*. at ¶ 11.
[101] *Id*. at ¶ 13.
[102] *Id*. at ¶ 14.

67. The cell was not cleaned or disinfected prior to her new cellmate's arrival.[103]

68. Despite displaying these symptoms, Ms. Connolly was never tested for COVID-19.[104]

69. Similarly, putative class member Terry Suggs, a 35-year-old man held as a pretrial detainee at ACJ on nonviolent charges, had a fever last week and was not seen by medical staff for over 5 days. When he was finally seen, medical staff said the fever was caused by his high blood pressure.[105]

70. Mr. Suggs has been diagnosed with asthma, diabetes and hypertension, conditions that have substantially limited his respiratory, digestive and circulatory systems, placing him at high risk of severe illness or death if he contracts COVID-19.[106]

71. Medical staff did not provide any follow up care to Mr. Suggs and did not take his temperature again.[107]

72. Mr. Suggs was not placed in isolation and no precautions were taken for those who were confined on the same pod or who otherwise had interaction with Mr. Suggs.[108]

73. Given the near insurmountable burden that COVID-19 has placed on healthcare systems across the world, there is a near-certain risk that ACJ's under-resourced healthcare staff will be overwhelmed by COVID-19.

---

[103] *Id.*
[104] *Id.* at ¶ 15.
[105] Suggs Decl. ¶ 24.
[106] Amon Decl. ¶ 14.
[107] *Id.*
[108] *Id.*

74. Defendants-Respondents have failed to respond to and manage the continued risk of harm posed by the COVID-19 outbreak by following public health guidelines from the Centers for Disease Control and Prevention ("CDC").[109] The guidelines require: (a) providing all incarcerated persons a six-foot radius (113 ft^2) or more of distance from any other persons, including during meals, transportation, court sessions, recreation, counts, and all other activities; (b) instituting a safety plan to prevent a COVID-19 outbreak in the ACJ in accordance with CDC guidelines; (c) making sanitation solutions readily available, without charge, for the purposes of cleaning cell, dormitory, laundry, and eating areas, including sufficient antibacterial soap, and lifting any ban on alcohol-based hygiene supplies (e.g. hand sanitizer, cleaning wipes); (d) providing adequate and appropriate COVID-19 testing for incarcerated persons, jail staff, and visitors; (e) waiving all medical co-pays for those experiencing COVID-19 like symptoms; and (f) providing sufficient personal protective equipment, particularly masks, and to all staff and incarcerated people.[110]

IV. CLASS ACTION ALLEGATIONS

75. Plaintiffs Graham, Diggs, and Connolly bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedures on behalf of themselves and a class of similarly situated individuals.

76. Plaintiffs Graham, Diggs, and Connolly seek to represent a class of all current and future detainees held in custody at ACJ ("Class"), including two subclasses: (1) persons who, by

---

[109] Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[110] Amon Decl. ¶¶ 24-25, n. 29.

reason of age or medical condition, are particularly vulnerable to injury or death if they were to contract COVID-19 ("Medically-Vulnerable Subclass"), and (2) persons who, by reason of their disability, are particularly vulnerable to injury or death if they were to contract COVID-19 ("Disability Subclass).

77. The "Medically Vulnerable" subclass is defined as all current and future persons held at ACJ who are 55 and older,[111] as well as all current and future persons held at ACJ of any age who have been diagnosed with: (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy. All plaintiffs represent the Medically Vulnerable Subclass.

78. The "Disability" subclass is defined as all current and future persons held at ACJ who have a physical impairment that substantially limits one or more of their major life activities and who are at increased risk of COVID-19 illness, injury, or death due to their disability or any medical treatment necessary to treat their disability, including but not limited to those who have been diagnosed with: (a) lung disease, including asthma, chronic obstructive pulmonary disease

[111] Amon Decl. ¶ 9.

(e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders and/or (i) developmental disability.[112] All plaintiffs represent the Disability Subclass.

79. This action has been brought and may properly be maintained as a class action under Federal law. It satisfies the numerosity, commonality, typicality, and adequacy requirements for maintaining a class action under Fed. R. Civ. P. 23(a).

80. Joinder is impracticable because (1) the classes are numerous; (2) the classes include unidentifiable future members; and (3) the class members are incarcerated, rendering their ability to institute individual lawsuits limited, particularly in light of the cessation of legal visitation and court closures in Allegheny County.

81. On information and belief, there are at least 1700 people in the proposed Pretrial Class. The information as to the exact size of the class and sub-class and the identity of the individuals therein are in the exclusive control of the Defendants.

82. Common questions of law and fact exist as to all members of the proposed classes: All have the right to receive adequate COVID-19 prevention, testing, and treatment.

---

[112] The disability subclass is separate and apart from the medically vulnerable class as age, and some conditions within the medically vulnerable class, such as pregnancy, are not factors that place a person under the ambit of the ADA's protections.

83. Plaintiffs' claims are typical of the members of the class because Plaintiffs and all class members are injured by the same wrongful acts, omissions, polices, and practices of Defendants-Respondents as described in this Complaint. Plaintiffs' claims arise from the same practices and courses of conduct that give rise to the claims of the class members, and are based on the same legal theories.

84. Plaintiffs Graham, Diggs, and Connolly have the requisite personal interest in the outcome of this action and will fairly and adequately protect the interests of the class. They have no interests adverse to the interests of the proposed class. They retained *pro bono* counsel with experience and success in the prosecution of civil rights litigation. Counsel for Plaintiffs know of no conflicts among proposed class members or between counsel and proposed class members.

85. Defendants have acted on grounds generally applicable to all proposed class members, and this action seeks declaratory and injunctive relief. Plaintiffs Graham, Diggs, and Connolly therefore seek class certification under Rule 23(b)(2).

86. In the alternative, the requirements of Rule 23(b)(1) are satisfied, because prosecuting separate actions would create a risk of inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of contact for the party opposing the proposed classes.

V. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

Unconstitutional Conditions of Confinement in Violation of the Fourteenth Amendment to the U.S. Constitution

42 U.S.C. § 1983/28 U.S.C. § 2241

Class & Medically Vulnerable Subclass versus All Defendants

87. Under the Fourteenth Amendment, corrections officials are required to provide for the reasonable health and safety of persons in pretrial custody. *Youngberg v. Romeo*, 457 U.S. 307,

315–16, 324 (1982)). Correctional officials thus have an affirmative obligation to protect persons in their custody from infectious disease. Officials violate incarcerated individuals' rights when they are deliberately indifferent to conditions of confinement that are likely to cause them serious illness and that pose an unreasonable risk of serious damage to their future health. *Helling v. McKinney*, 509 U.S. 25, 33-34 (1993)

88. Defendants-Respondents' actions in confronting the COVID-19 threat have been worse than deliberately indifferent. Defendants-Respondents have misused the opportunity provided by Allegheny County courts in reducing its population by 600 people. Rather than take advantage of the additional space to operationalize the recommended social distancing, Defendants-Respondents have consolidated incarcerated persons, thereby intentionally increasing risk of likely contagion and the severe resulting health consequences.

89. Moreover, ACJ, as currently operated, is unable to comply with public health guidelines to prevent an outbreak of COVID-19, and Defendants-Respondents have not and cannot provide for the safety of the Class. Defendants-Respondents have not taken appropriate steps to test for, treat, or prevent COVID-19 outbreaks, and Defendants-Respondents are unable to protect the sub-class of medically vulnerable inmates from serious harm caused by COVID-19, in violation of their constitutional obligation to provide humane conditions of confinement for the Class.

90. Accordingly, Defendants have violated the rights of the Class under the Fourteenth Amendment.

SECOND CLAIM FOR RELIEF

Unconstitutional Punishment in Violation of the Fourteenth Amendment to the U.S. Constitution
42 U.S.C. § 1983/28 U.S.C. § 2241
Class & Medically Vulnerable Subclass versus All Defendants

91. Under the Fourteenth Amendment, persons in pretrial custody have greater due process protections than those convicted and therefore cannot be punished as part of their detention. *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979). A Defendant has punished Plaintiffs when the conduct is either not rationally related to a legitimate, non-punitive governmental purpose or excessive in relation to that purpose.

92. Even assuming that Defendants-Respondents' spacing and provision of medical services inside ACJ normally serves the legitimate, non-punitive purpose of health and safety of detained persons, ACJ, as currently operated, has been deliberately indifferent to and is unable to comply with public health guidelines to prevent an outbreak of COVID-19. Therefore, continuing to detain Class members under conditions of confinement that are inconsistent with COVID-19-specific guidance from public health experts is not rationally related to, and excessive in relation to, that purpose.

93. Accordingly, Defendants have violated the rights of the Class under the Fourteenth Amendment.

THIRD CLAIM FOR RELIEF

Violation of the Americans with Disabilities Act
42 U.S.C. §§ 12101 et seq
Disability Subclass versus Defendant Allegheny County

94. Title II of the ADA requires public entities, like ACJ, to reasonably accommodate people with disabilities in all programs and services for which people with disabilities are otherwise qualified.

95. Plaintiffs, and other members of the Class, are qualified individuals with a disability under the meaning of the ADA.

96. Access to medical treatment and safe conditions of confinement are programs or services that ACJ must provide to incarcerated people for purposes of the ADA.

97. Defendants intentionally discriminate against people with disabilities by intentionally denying them reasonable accommodations recommended by the CDC and necessary to protect themselves from COVID-19.

98. If the population is reduced to allow for adequate social distancing, reasonable accommodations recommended by the CDC and necessary to protect people with disabilities include, but are not limited to: single celling, provision of cleaning supplies, access to soap to facilitate handwashing, and staggered dining and recreation times in numbers that permit social distancing.

99. Failing to provide these reasonable accommodations is illegal discrimination under the ADA entitling Plaintiffs and members of the Disability Subclass to injunctive and declaratory relief.

VI. REQUEST FOR RELIEF

100. Plaintiffs/Petitioners Graham, Diggs, and Connolly and Class Members respectfully request that the Court order the following:

1. Certification of this Petition as a Class Action.
2. A preliminary injunction, permanent injunction, and/or writs of habeas corpus requiring Defendants-Respondents to immediately release all Medically Vulnerable Subclass Members, absent proof of recorded judicial findings that the individual poses a risk of flight

or danger to others that no other conditions can mitigate, and ordering that Defendants-Respondents provide these individuals with educational resources on COVID-19, including instructions that they should self-isolate for the CDC-recommended period of time (currently 14 days) following release.

3. A preliminary injunction directing any further action required to release Class Members outside the Medically Vulnerable Subclass to ensure that all remaining persons are incarcerated in Allegheny County Jail under conditions consistent with CDC guidance to prevent the spread of COVID-19, including requiring that all persons be able to maintain six feet or more of space between them.
4. A preliminary injunction enjoining Defendants-Respondents from confining more than one person in a cell until such time as the danger of contagion from COVID-19 recedes sufficiently to lift social distancing requirements.
5. A preliminary injunction directing Defendant-Respondents to submit a plan to the Court within five days, to be overseen by a qualified public health expert pursuant to Fed. R. Evid. 706, which outlines:
    a. Specific mitigation efforts, in line with CDC guidelines, to significantly reduce the risk of contraction of COVID-19 by all Class Members not immediately released;
    b. A housing and/or public support plan for any released Class or Subclass Members whose testing confirms they have been exposed to or infected with COVID-19 and who do not readily have a place to self-isolate for the CDC-recommended period of time (currently 14 days); and

c. An evaluation of whether the release of the Subclass Members permits social distancing and whether other categories of prisoners must be released to provide for compliance with CDC guidelines.

6. If immediate release is not granted on the basis of this Petition alone, then expedited review of the Petition, including an evidentiary hearing and/or oral argument, via telephonic or videoconference if necessary.
7. A declaration that Defendants-Respondents policies violate the Fourteenth Amendment rights to reasonable safety and to be free from punishment prior to conviction with respect to the Class and/or Medically Vulnerable Subclass.
8. A declaration that Defendants-Respondents' policies violate the Americans with Disabilities Act with respect to the Disability Subclass.
9. An award of Petitioners/Plaintiffs' attorney fees and costs under 42 U.S.C. § 1988, 42 U.S.C. § 12205, and other applicable law.
10. Any further relief this Court deems just and appropriate.

Dated: April 7, 2020

Respectfully submitted,

/s/ Alexandra Morgan-Kurtz
Alexandra Morgan-Kurtz, Esq.
PA ID No. 312631
Pennsylvania Institutional Law Project
100 Fifth Ave, Ste. 900
Pittsburgh, Pa 15222
T: (412) 434-6175
amorgan-kurtz@pailp.org

/s/ Bret Grote
Bret D. Grote, Esq.
PA ID No. 317273
/s/ Quinn Cozzens
Quinn Cozzens, Esq.
PA ID No. 323353
*/s/ Jaclyn Kurin**
Jaclyn Kurin, Esq.
D.C. Bar ID No. 1600719
*/s/ Jules Lobel,**
Jules Lobel, Esq.
Of Counsel
N.Y. Bar No. 1262732
/s/ Swain Uber
Swain Uber, Esq.
Of Counsel
PA I.D. No. 323477
Abolitionist Law Center
P.O. Box 8654
Pittsburgh, PA 15221
T: (412) 654-9070
bretgrote@abolitionistlawcenter.org
qcozzens@alcenter.org
jkurin@alcenter.org
jll4@pitt.edu
swain.uber@gmail.com

**pro hac vice admission pending*

/s/ Sara J. Rose
Sara J. Rose, Esq.
PA ID No.: 204936
/s/ Witold J. Walczak
Witold J. Walczak, Esq.
PA ID No.: 62976
American Civil Liberties Union of Pennsylvania
PO Box 23058
Pittsburgh, PA 15222
T: (412) 681-7864 (tel.)
F: (412) 681-8707
srose@aclupa.org
vwalczak@aclupa.org

David C. Fathi*
dfathi@aclu.org

AMERICAN CIVIL LIBERTIES UNION FOUNDATION,
NATIONAL PRISON PROJECT
915 15th Street N.W. 7th Floor
Washington, DC 20005
(202) 548-6603

*Not admitted in DC; practice limited to federal courts

Sozi Pedro Tulante, Esq.
PA ID No. 202579
Will W. Sachse, Esq.
PA ID No.: 84097
Cory A. Ward, Esq.
PA ID No. 320502
Ryan M. Moore, Esq.
PA ID No. 314821
Rachel Rosenberg, Esq.
PA ID No. 322960
Dechert LLP
Cira Centre
2929 Arch Street
Philadelphia, PA 19104-2808
T: (215) 994-2496
F: (215) 665-2496
Sozi.tulante@dechert.com
will.sachse@dechert.com
cory.ward@dechert.com
**pro hac vice pending*

Attorneys for Petitioners/Plaintiffs

JS 44 (Rev. 02/19)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

DEFENDANTS

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ❒ 1 U.S. Government Plaintiff
- ❒ 2 U.S. Government Defendant
- ❒ 3 Federal Question *(U.S. Government Not a Party)*
- ❒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	❒ 1	❒ 1	Incorporated *or* Principal Place of Business In This State	❒ 4	❒ 4
Citizen of Another State	❒ 2	❒ 2	Incorporated *and* Principal Place of Business In Another State	❒ 5	❒ 5
Citizen or Subject of a Foreign Country	❒ 3	❒ 3	Foreign Nation	❒ 6	❒ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ❒ 110 Insurance
- ❒ 120 Marine
- ❒ 130 Miller Act
- ❒ 140 Negotiable Instrument
- ❒ 150 Recovery of Overpayment & Enforcement of Judgment
- ❒ 151 Medicare Act
- ❒ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ❒ 153 Recovery of Overpayment of Veteran's Benefits
- ❒ 160 Stockholders' Suits
- ❒ 190 Other Contract
- ❒ 195 Contract Product Liability
- ❒ 196 Franchise

REAL PROPERTY
- ❒ 210 Land Condemnation
- ❒ 220 Foreclosure
- ❒ 230 Rent Lease & Ejectment
- ❒ 240 Torts to Land
- ❒ 245 Tort Product Liability
- ❒ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ❒ 310 Airplane
- ❒ 315 Airplane Product Liability
- ❒ 320 Assault, Libel & Slander
- ❒ 330 Federal Employers' Liability
- ❒ 340 Marine
- ❒ 345 Marine Product Liability
- ❒ 350 Motor Vehicle
- ❒ 355 Motor Vehicle Product Liability
- ❒ 360 Other Personal Injury
- ❒ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ❒ 365 Personal Injury - Product Liability
- ❒ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ❒ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ❒ 370 Other Fraud
- ❒ 371 Truth in Lending
- ❒ 380 Other Personal Property Damage
- ❒ 385 Property Damage Product Liability

CIVIL RIGHTS
- ❒ 440 Other Civil Rights
- ❒ 441 Voting
- ❒ 442 Employment
- ❒ 443 Housing/ Accommodations
- ❒ 445 Amer. w/Disabilities - Employment
- ❒ 446 Amer. w/Disabilities - Other
- ❒ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ❒ 463 Alien Detainee
- ❒ 510 Motions to Vacate Sentence
- ❒ 530 General
- ❒ 535 Death Penalty

Other:
- ❒ 540 Mandamus & Other
- ❒ 550 Civil Rights
- ❒ 555 Prison Condition
- ❒ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ❒ 625 Drug Related Seizure of Property 21 USC 881
- ❒ 690 Other

LABOR
- ❒ 710 Fair Labor Standards Act
- ❒ 720 Labor/Management Relations
- ❒ 740 Railway Labor Act
- ❒ 751 Family and Medical Leave Act
- ❒ 790 Other Labor Litigation
- ❒ 791 Employee Retirement Income Security Act

IMMIGRATION
- ❒ 462 Naturalization Application
- ❒ 465 Other Immigration Actions

BANKRUPTCY
- ❒ 422 Appeal 28 USC 158
- ❒ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ❒ 820 Copyrights
- ❒ 830 Patent
- ❒ 835 Patent - Abbreviated New Drug Application
- ❒ 840 Trademark

SOCIAL SECURITY
- ❒ 861 HIA (1395ff)
- ❒ 862 Black Lung (923)
- ❒ 863 DIWC/DIWW (405(g))
- ❒ 864 SSID Title XVI
- ❒ 865 RSI (405(g))

FEDERAL TAX SUITS
- ❒ 870 Taxes (U.S. Plaintiff or Defendant)
- ❒ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ❒ 375 False Claims Act
- ❒ 376 Qui Tam (31 USC 3729(a))
- ❒ 400 State Reapportionment
- ❒ 410 Antitrust
- ❒ 430 Banks and Banking
- ❒ 450 Commerce
- ❒ 460 Deportation
- ❒ 470 Racketeer Influenced and Corrupt Organizations
- ❒ 480 Consumer Credit
- ❒ 485 Telephone Consumer Protection Act
- ❒ 490 Cable/Sat TV
- ❒ 850 Securities/Commodities/ Exchange
- ❒ 890 Other Statutory Actions
- ❒ 891 Agricultural Acts
- ❒ 893 Environmental Matters
- ❒ 895 Freedom of Information Act
- ❒ 896 Arbitration
- ❒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ❒ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ❒ 1 Original Proceeding
- ❒ 2 Removed from State Court
- ❒ 3 Remanded from Appellate Court
- ❒ 4 Reinstated or Reopened
- ❒ 5 Transferred from Another District *(specify)*
- ❒ 6 Multidistrict Litigation - Transfer
- ❒ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:

Brief description of cause:

VII. REQUESTED IN COMPLAINT:

❒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ❒ Yes ❒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

JS 44A REVISED June, **2009**
IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA
THIS CASE DESIGNATION SHEET MUST BE COMPLETED

PART A

This case belongs on the (Erie Johnstown Pittsburgh) calendar.

1. **ERIE CALENDAR -** If cause of action arose in the counties of Crawford, Elk, Erie, Forest, McKean. Venang or Warren, OR any plaintiff or defendant resides in one of said counties.

2. **JOHNSTOWN CALENDAR -** If cause of action arose in the counties of Bedford, Blair, Cambria, Clearfield or Somerset OR any plaintiff or defendant resides in one of said counties.

3. Complete if on **ERIE CALENDAR:** I certify that the cause of action arose in_____ County and that the _____resides in_____County.

4. Complete if on **JOHNSTOWN CALENDAR:** I certify that the cause of action arose in _____County and that the_____resides in _____County.

PART B (You are to check ONE of the following)

1. This case is related to Number_____ . Short Caption_____._____
2. This case is not related to a pending or terminated case.

DEFINlTIONS OF RELATED CASES:

CIVIL: Civil cases are deemed related when a case filed relates to property included in another suit or involves the same issues of fact or it grows out of the same transactions as another suit or involves the validity or infringement of a patent involved in another suit EMINENT DOMAIN: Cases in contiguous closely located groups and in common ownership groups which will lend themselves to consolidation for trial shall be deemed related. HABEAS CORPUS & CIVIL RIGHTS: All habeas corpus petitions filed by the same individual shall be deemed related. All pro se Civil Rights actions by the same individual shall be deemed related.

PARTC

I. CIVIL CATEGORY (Select the applicable category).

1. Antitrust and Securities Act Cases
2. Labor-Management Relations
3. Habeas corpus
4. Civil Rights
5. Patent, Copyright, and Trademark
6. Eminent Domain
7. All other federal question cases
8. All personal and property damage tort cases, including maritime, FELA, Jones Act, Motor vehicle, products liability, assault, defamation, malicious prosecution, and false arrest
9. Insurance indemnity, contract and other diversity cases.
10. Government Collection Cases (shall include HEW Student Loans (Education), V A 0verpayment, Overpayment of Social Security, Enlistment Overpayment (Army, Navy, etc.), HUD Loans, GAO Loans (Misc. Types), Mortgage Foreclosures, SBA Loans, Civil Penalties and Coal Mine Penalty and Reclamation Fees.)

I certify that to the best of my knowledge the entries on this Case Designation Sheet are true and correct

Date: _____ _____

ATTORNEY AT LAW

NOTE: ALL SECTIONS OF BOTH FORMS MUST BE COMPLETED BEFORE CASE CAN BE PROCESSED.

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket. **PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

Declaration of Joseph J. Amon, Ph.D. MSPH

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.

2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.

3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.

4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of today (4/3), according to the World Health Organization 932,166 confirmed cases have been diagnosed in 205 countries or territories around the world and more than 46,764 deaths due to COVID-19 have been reported.[1] In the United States, which has the highest number of reported cases in the world, 245,573 confirmed cases have been reported with the disease and 6,058 people have died thus far,[2] though these numbers likely

[1] See https://www.who.int/emergencies/diseases/novel-coronavirus-2019 accessed April 3, 2020.
[2] See https://coronavirus.jhu.edu/map.html accessed April 3, 2020

underreport the actual infections and deaths.[3] In Pennsylvania, as of 12:00 pm on April 5, 2020, there were 11,510 confirmed cases and 150 deaths reported by the state department of health.[4] Since March 6, there have been 1,072 individuals hospitalized due to COVID-19, with 98% of those cases occurring in individuals age 25 years or older.[5] There has been an exponential increase in cases and deaths in Pennsylvania over the past three weeks with the number of people infected increasing, on average, by 32% every day[6]:

Date	Cases (cumulative)	Deaths (cumulative)
12-Mar	28	0
13-Mar	41	0
14-Mar	58	0
15-Mar	63	0
16-Mar	76	0
17-Mar	96	0
18-Mar	133	1
19-Mar	185	1
20-Mar	268	1
21-Mar	371	2
22-Mar	479	3
23-Mar	644	6
24-Mar	851	7
25-Mar	1,127	11
26-Mar	1,687	16
27-Mar	2,218	22
28-Mar	2,751	34
29-Mar	3,394	38
30-Mar	4,087	48
31-Mar	4,843	63
1-April	5,805	74
2-April	7,016	90
3-April	8,420	102
4-April	10,017	136
5-April	11,510	150

[3] See https://www.washingtonpost.com/national/us-deaths-from-coronavirus-top-1000-amid-incomplete-reporting-from-authorities-and-anguish-from-those-left-behind/2020/03/26/2c487ba2-6ad0-11ea-9923-57073adce27c_story.html accessed April 3, 2020.

[4] See https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID-19%20Situation%20Reports/20200325nCoVSituationReportExt.pdf; accessed April 5, 2020 see also: https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx accessed April 5, 2020

[5] Ibid.

[6] See http://91-divoc.com/pages/covid-visualization/ accessed April 5, 2020

6. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections.

7. The World Health Organization (WHO) identifies individuals at highest risk to include those over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.[7] The WHO further states that the risk of severe disease increases with age starting from around 40 years.

8. The US CDC identifies "older adults [65 and older] and people of any age who have serious underlying medical conditions" as at higher risk of severe disease and death.[8] The CDC identifies underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease ("including asthma or chronic obstructive pulmonary disease [chronic bronchitis or emphysema] or other chronic conditions associated with impaired lung function"), neurological and neurologic and neurodevelopmental conditions "[including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability…"], and current or recent pregnancy.[9] The CDC also identifies individuals with a body mass index (BMI) greater than 40 to be at higher risk for severe illness.[10] Based upon reports of a high proportion of ICU patients with cerebrovascular disease and diabetes, some researchers have speculated that increased risk of severe illness may be associated with common medicines (ACE2-stimulating drugs) prescribed for hypertension and diabetes.[11]

9. Data from US COVID-19 cases published by the CDC on March 19, 2020, found that hospitalization rates and intensive care unit (ICU) admission rates were nearly identical for individuals aged 45-54 and individuals aged 55-64 (between approximately 20-30% for both groups for hospitalization and between 5-11% for both

---

[7] See https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_4 accessed March 21, 2020

[8] See https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html accessed March 21, 2020

[9] See https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf accessed March 21, 2020

[10] See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html accessed April 3, 2020

[11] See https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30116-8/fulltext?fbclid=IwAR2oRXHweQuw3CLmgJuAh7q556SJ83lnw4m8_G9LK8GtppeAPUtwGG1Fn9o accessed April 3, 2020

groups for ICU admission).[12] This suggests that individuals >45 years could be considered high risk for severe disease while those ≥54 years could be considered high risk for severe disease and death.

Health profile of declarants

10. I have reviewed the declarations of the following individuals and/or the attorneys for the following individuals: Heather Connolly, Alexus Diggs, Larnell Jones, Terry Suggs, and Michael Graham.

11. Heather Connolly is a 48 year old woman who reports having hepatitis C, a viral infection of the liver commonly associated with liver disease. This conditions indicates that she is likely at heightened risk for severe illness and death from COVID-19. She also indicates current symptoms of fever and that her cellmate was ill with a high fever.

12. Alexus Diggs is a 24 year old woman who reports having high blood pressure. Hypertension is a form of cardiovascular disease and may be associated with other conditions such as atherosclerosis. Because of her hypertension, Ms. Diggs may be at increased risk of severe disease or death due to COVID-19.

13. Larnell Jones is a 45 year old man who reports having asthma and hypertension which indicates that his is likely at heightened risk for severe disease and death from COVID-19.

14. Terry Suggs is a 35 year old man who reports having asthma, hypertension, and diabetes, all of which likely puts him at heightened risk for severe disease and death from COVID-19.

15. Michael Graham is a 38 year old man who reports having hepatitis C and asthma, both of which likely puts him at heightened risk for severe disease and death from COVID-19.

Understanding of COVID-19 Transmission

16. According to the US CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.[13] It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.[14]

---

[12] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm, accessed March 21, 2020
[13] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html accessed March 21, 2020
[14] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020

17. People are thought to be most contagious when they are most symptomatic (the sickest), however there is increasing evidence of asymptomatic[15] and presymptomatic transmission. A recent report by the CDC of presymptomatic transmission in Singapore identified seven clusters of COVID-19 in which presymptomatic transmission likely occurred, accounting for 6.4% of locally acquired cases examined.[16] These findings are similar to research outside of Hubei province, China, which found that 12.6% of transmissions could have occurred before symptom onset in the source patient.[17] Speech and other vocal activities such as singing have been shown to generate air particles which could transmit the virus responsible for COVID-19, with the rate of emission corresponding to voice loudness. News outlets have reported that during a choir practice in Washington on March 10, presymptomatic transmission likely played a role in SARS-CoV-2 transmission to approximately 40 of 60 choir members.[18]

18. **The understanding of direct transmission as the most likely means of SARS-CoV-2 transmission combined with evidence of asymptomatic and presymptomatic transmission suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.**

19. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.[19] Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. Earlier this month Pennsylvania Governor, Tom Wolf, declared a state of emergency, which he buttressed on March 19 with an order closing non-essential businesses.[20] On April 1, Governor Wolf extended county-by-county stay at home orders to cover the entire state of Pennsylvania.[21] These kinds of orders are quickly spreading nationwide, after beginning in California on March 19. As of April 2, at least 297 million people in at least 38 states, 48 counties, 14 cities, the District of Columbia, and Puerto Rico are being directed to stay home.[22]

---

[15] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020; See also: Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19.JAMA. Published online February 21, 2020. doi:10.1001/jama.2020.2565 and Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020;9(1):386-389.

[16] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e1.htm?s_cid=mm6914e1_w accessed April 2, 2020

[17] See https://wwwnc.cdc.gov/eid/article/26/6/20-0357_article accessed April 2, 2020

[18] See https://www.latimes.com/world-nation/story/2020-03-29/coronavirus-choir-outbreak accessed April 2, 2020

[19] See https://www.astho.org/COVID-19/ accessed March 21, 2020

[20] See https://www.governor.pa.gov/wp-content/uploads/2020/03/20200319-TWW-COVID-19-business-closure-order.pdf

[21] See https://www.governor.pa.gov/newsroom/gov-wolf-sec-of-health-pennsylvania-on-statewide-stay-at-home-order-beginning-at-8-pm-tonight-most-prudent-option-to-stop-the-spread/ accessed April 2, 2020.

[22] See https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html accessed April 2, 2020.

20. These public health measures aim to "flatten the curve" of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.

21. US cities are starting to see the level of COVID-19 cases seen in previous global hotspots. On Thursday, March 26, Governor Cuomo announced that 100 people had died of the coronavirus between Wednesday and Thursday morning. [23] As of Friday, March 27, the cumulative death toll in the state stood at 450.[24] In response, the city's health commissioner again urged all New Yorkers to follow the stay at home order, emphasizing the impact on the city's already strained health system.[25] As of April 1, 2020, New York's death toll had reached 1,374.[26] Pennsylvania is roughly 10 days behind New York City, following a similar trendline of cases and deaths.[27]

Risk of COVID-19 in Jail Facilities

22. The conditions of jail facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

23. Jails are enclosed environments. These kinds of enclosed environments, like cruise ships and nursing homes, have seen higher rates of COVID-19 infection than the general population. Jails have even greater risk of COVID-19 transmission than other enclosed environments because of crowding within the facility, and limited access to hygiene, and structural limitations. People in jails are housed in crowded spaces of limited size and are subjected to security measures that force them into close contact with guards. They cannot practice the "social distancing" necessary to effectively prevent the spread of COVID-19. Bathrooms facilities—toilets, showers, and sinks—and other common areas are shared, without adequate surface disinfection between users. Food preparation and distribution without proper precautions also presents a further site for the virus to spread. Infectious spread presents a particular challenge in these facilities where the population often is disproportionately vulnerable, while facilities provide limited

---

[23] See https://www.nytimes.com/2020/03/26/world/coronavirus-news.html?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu#link-18cce12f accessed March 26, 2020.

[24] https://nypost.com/2020/03/27/another-84-people-killed-by-coronavirus-in-new-york-city/ accessed March 28, 2020.

[25] See https://nypost.com/2020/03/25/de-blasio-warns-half-of-all-new-yorkers-will-get-covid-19/ accessed March 26, 2020.

[26] See https://coronavirus.jhu.edu/map.html accessed April 1, 2020.

[27] See https://www.businessinsider.com/new-york-city-coronavirus-cases-over-time-chart-2020-3 accessed March 26, 2020.

medical care.[28]

24. CDC guidance on correctional and detention facilities,[29] posted March 23, 2020, specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons "ideally 6 feet between all individuals, regardless of the presence of symptoms" including: 1) increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.

25. The CDC guidance also describes necessary disinfection procedures including to thoroughly clean and disinfect all areas where a confirmed or suspected COVID-19 case spent time.[30]

26. Based upon the declarations I reviewed (paragraph 10 above), Allegheny County Jail (ACJ) does not appear to be adopting the procedures necessary to prevent COVID-19 transmission. The infrastructure and routine practice of Allegheny County Jail raise significant challenges to maintaining distancing between detainees in the facilities. These physical infrastructure and security challenges, which are typical of most detention centers, include:
    - Individuals are held for extended periods of time in the intake area, typically with 10 or more people sharing a single toilet and sink. Only cursory medical screening is conducted.
    - A significant number of people housed at ACJ are double-celled.
    - Access to soap is a constant problem in ACJ as is, in some pods, access to personal hygiene and cleaning supplies.
    - There are only a few showers per pod, with many people sharing the same shower area, without any sanitation between individual uses.
    - Dining tables are small and fit four people, with one person on each side. A table is only four feet by four feet, at most, so no one can social distance from others during meal times.
    - As is true in detention facilities generally, communal bathroom facilities pose a risk of transmission and it is not usually possible for an incarcerated person to move throughout ACJ without coming into contact with many other people. The use of elevators also poses a problem bringing individuals in close contact. If someone is housed in a special unit or restrictive housing, they must also be closely escorted everywhere in the facility and security incidents can put an

[28] https://www.prisonpolicy.org/health.html accessed March 26, 2020.
[29] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

[30] Ibid

incarcerated person into close contact with staff members.

- Access to medical care is inadequate at ACJ. There are extreme delays in individuals' ability to access care, as well as huge staffing shortages.

27. Based upon the information provided to me, and my prior knowledge of detention facilities, I am concerned that the Alleghany County Jail does not have the ability to implement the critically important principle of social distancing, such as maintain six feet of separation at all times including meals and location of beds. Where detention facilities are housing detained individuals in small cells where they are bunked together and where they are crowded together to eat meals, they will not be able to prevent COVID-19 transmission once introduced into the jail.

28. Nor am I aware of the necessary measures being taken at the Alleghany County Jail to identify and properly isolate individuals at high risk, those with potential exposure (e.g., from work detail) or those with symptoms consistent with COVID-19. These steps are essential to preventing transmission of COVID-19.

29. Introduction of new people into detention facilities who have had contact with the community outside the facility—be it correctional officers and other staff, new individuals coming into custody, people on work release, or individuals serving intermediate sentences—creates a link from transmission occurring in the community to those who are detained. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection.

30. The alternative is to test all staff and detainees entering the facility. However, this would require frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities (that included Philadelphia, Pittsburgh, Erie, and Easton), 92.1% of cities reported that they do not have an adequate supply of test kits.[31] Shortages are likely to become more severe over the next three to four weeks when there will be a major shortage of chemical reagents for COVID-19 testing and enormous increases in demand.[32] Given the shortage of COVID-19 testing in the United States, it is likely that jails are and will continue to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history– all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place.

[31] https://www.usmayors.org/issues/covid-19/equipment-survey/ accessed March 28, 2020.

[32] https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html accessed March 28, 2020.

Heightened Rates of COVID-19 Infection and Spread Within Detention Facilities

31. The rates of spread in the facilities that have been testing for COVID-19 illustrates the dangers the conditions in these facilities pose to those who are detained there, and to the broader community. In Cook County Jail, Chicago in a matter of two days, the number of individuals infected jumped from 38 inmates[33] to 89 inmates and 12 staff members.[34], As of April 1, there were 167 confirmed cases among detained individuals, even after the jail released 400 individuals.[35] At Rikers Island in New York, on Saturday March 21, a jail oversight agency indicated that 21 inmates and 17 employees tested positive.[36] Four days later, on Wednesday, March 26, 75 inmates and 37 employees tested positive.[37] As of Tuesday, March 31, 141 staff and 180 individuals in custody had tested positive at Rikers and city jails in New York City.[38] **The Legal Aid Society in New York recently reported that the infection rate for COVID-19 at local jails is more than seven times higher than the rate citywide and 87 times higher than the country at large.[39]**

32. The data above also confirms high rates of infection among correctional officers and other staff. These individuals all face an increased risk of COVID-19 exposure as they are less able to practice the recommended strategy of social distancing in carrying out their official duties. If corrections officers are significantly affected by COVID-19, whether through being infected, exposed by detainees, their fellow officers or in the community, large numbers will be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

33. At least one detained individual from Pike County Correctional Facility and at least 3 staff and one contract employee have already tested positive for COVID-19.[40] The detained individual was so ill that they had to be hospitalized for the infection. Pike County, as of April 1, 2020, has reported 57 cases and 1 death due to COVID-19. York has had 79 reported cases.[41] These are likely underestimates. It is reasonable to expect

---

[33] See https://www.nbcchicago.com/news/local/cook-county-jail-says-17-inmates-have-tested-positive-for-coronavirus/2244652/ accessed March 26, 2020.

[34] See https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387 accessed March 29, 2020.

[35] See https://www.nbcchicago.com/news/local/167-cook-county-jail-detainees-have-tested-positive-for-covid-19-officials-say/2248892/ accessed April 2, 2020.

[36] https://www.nbcnewyork.com/news/coronavirus/21-inmates-17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242/ accessed March 23, 2020.

[37] See https://nypost.com/2020/03/25/new-coronavirus-cases-in-nyc-jails-outpacing-rest-of-the-city/ accessed March 26, 2020

[38] See https://www.theguardian.com/us-news/2020/apr/01/rikers-island-jail-coronavirus-public-health-disaster accessed April 2, 2020.

[39] See: https://newyork.cbslocal.com/2020/03/26/coronavirus-rikers-island/ accessed March 26, 2020

[40] https://news.pikepa.org/post/2020/03/09/COVID-19-Update accessed April 3, 2020.

[41] https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx accessed April 1, 2020.

this kind of introduction of COVID-19 into the detention facilities from staff exposed in the community given the current local transmission of COVID-19 in Pennsylvania, reflecting the continued movement of people between specific locales.

Infrastructure in Detention Facilities Will Likely Be Insufficient to Address Needs of COVID-19 Patients

34. If COVID-19 enters into detention facilities, these facilities will likely be unable to address the infectious spread and the needs of infected individuals due to lack of testing and insufficient physical and medical infrastructure.

35. In cases where there are confirmed or suspected cases of COVID-19, the CDC recommends medical isolation, defined by the CDC confining the case "ideally to a single cell with solid walls and a solid door that closes" to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space.[42]

36. Individuals in close contact of a confirmed or suspected COVID-19 case - defined by the CDC as having been within approximately 6 feet of the individual for a prolonged period of time or having had direct contact with secretions of a COVID-19 case (e.g., have been coughed on) – should be quarantined for a period of 14 days. The same precautions should be taken for housing someone in quarantine as for someone who is a confirmed or suspected COVID-19 case put in isolation.[43]

37. The CDC guidance recognizes that housing detainees in isolation and quarantine individually, while "preferred", may not be feasible in all county jail settings and discusses the practice of "cohorting" when individual space is limited. The term "cohorting" refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a particular case together as a group. The guidance states specifically that "Cohorting should only be practiced if there are no other available options" and exhorts correctional officials: "**Do not cohort confirmed cases with suspected cases or case contacts."** [emphasis in original]. Individuals who are close contacts of different cases should also not be kept together.

38. The CDC guidance also says that detention facilities should "Ensure that cohorted cases wear face masks at all times."[44] This is critical because not all close contacts may be infected and those not infected must be protected from those who are if individuals are cohorted. However, it's important to note that face masks are in short supply. In a joint letter to President Trump, the American Medical Association, the American Hospital Association, and the American Nurses Association called on the administration to "immediately use the Defense Production Act to increase the domestic production of medical supplies and equipment that hospitals, health, health systems, physicians, nurses

[42] Ibid.
[43] Ibid
[44] Ibid

and all front line providers so desperately need."[45] In a survey United States cities, 91.5% of the cities reported that they do not have an adequate supply of face masks for their first responders and medical personnel.[46] There are also widespread shortages of personal protective equipment — particularly N-95 masks — sufficient to provide even for health care workers, in our nation's hospitals, let alone medical providers and other individuals coming into contact with the virus in county jails .[47] Many public health leaders are calling for masks to be reserved for health care staff, who face increased risk and are vitally needed to sustain emergency care. Hospitals in the New York City area, unable to access masks locally, are reportedly turning to a private distributor to airlift millions of protective masks out of China.[48] Face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it; and replacing the mask with a new one if it becomes damp (e.g., from sneezing) and not to re-use single-use masks. There are times when detainees will necessarily not be able to wear masks, if available. For example, during meals. In these instances, detainees should eat individually or with proper distancing from others.

39. Where individual rooms are not available, the CDC guidance describes a hierarchy of next best options for cohorting, which in order from lesser risk to greater risk includes housing individuals under medical isolation: 1) in a large, well-ventilated cell with solid walls and a solid door that closes fully; 2) in a large, well-ventilated cell with solid walls but without a solid door; 3) in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells; 4) in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells.[49]

40. Many jails and prisons also lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, jails often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

41. Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in the rural counties in which these detention facilities are located. If infection spreads throughout the detention center, overwhelming the center's own limited resources, the burden of caring for these individuals will shift to local medical facilities. The few facilities will likely not be able to provide care to all infected

[45] See: https://www.aha.org/lettercomment/2020-03-21-aha-ama-and-ana-letter-president-use-dpa-medical-supplies-and-equipment accessed March 26, 2020

[46] https://www.usmayors.org/issues/covid-19/equipment-survey/ accessed March 28, 2020.

[47] https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html accessed March 28, 2020.

[48] See: https://lancasteronline.com/news/health/hospital-suppliers-take-to-the-skies-to-combat-dire-shortages/article_0830ffb0-6f89-11ea-89ed-bbd859186614.html accessed March 26, 2020

[49] Ibid

individuals with serious cases, increasing the likelihood that these individuals will die.[50]

Conclusions

42. CDC guidance on correctional and detention facilities,[51] posted March 23, 2020 reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at "heightened" risk for COVID-19 infection once the virus is introduced; 2) There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

43. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

44. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released to home quarantine for 14 days. Where there is not a suitable location for home quarantine available, these individuals could be released to housing identified by the county or state Department of Health.

45. Other individuals who may not be identified as high risk should also be considered for release. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees and lessen the burden of ensuring the safety of detainees and corrections officers.

46. Given the physical infrastructure of facilities, the challenges of providing security

---

[50] See https://www.post-gazette.com/news/health/2020/03/20/Rural-counties-in-Pennsylvania-struggle-on-their-own-as-COVID-19-spreads/stories/202003180034 accessed March 23, 2002. Even in regions with highly developed health systems, COVID-19 is straining ability to care, creating cause for alarm for less-equipped health care systems in regions that do not act to mitigate risk of infection. See https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html accessed March 23, 2020

[51] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

without close contact, and the lack of proper equipment (such as masks) to prevent transmission, I do not believe detention facilities are equipped to ensure the safety of those in their custody. Releasing individuals at highest risk who can then self-isolate – either in their homes or in facilities arranged by the local department of health – provides a significantly better likelihood of preventing infection, disease spread and death, both in the facility and in the community at large.

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

Executed this fifth day in April 2020 in Princeton, New Jersey.

Joseph J. Amon, PhD MSPH

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of April 2, 2020, there are over 800,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 45,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States in regions like New York, New Jersey, Louisiana, Michigan and Illinois.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.

7. When a community or institution lacks a comprehensive and rigorous testing regime, a lack of proven cases of COVID-19 is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.

8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

10. There is no cure and vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

12. In early March, the highest known person-to-person transmission rates for COVID-19 were in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. More recently, the highest transmission rates have been recorded in the Rikers Island jail complex in New York City, which is over seven times the rate of transmission compared to the spread in New York City. To illustrate, the number of confirmed cases among inmates soared from one to nearly 200 in the matter of 12 days.

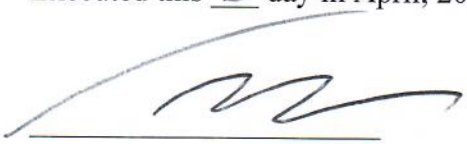
13. This is consistent with the spread of previous viruses in congregate settings. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to

adequate hygiene facilities, limited ability to physically distance themselves from others, and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 3 day in April, 2020 in Ann Arbor, Michigan.



Dr. Jonathan Louis Golob

Jonathan Louis Golob, M.D. Ph.D.
Assistant Professor
206 992-0428 (c) 734-647-3870 (o)
golobj@med.umich.edu jonathan@golob.org

Education and Training

6/1997 – 6/2001	**Bachelor of Science**, Johns Hopkins University, Baltimore, MD Dual degree in Biomedical Engineering and Computer Science conferred June 2001.
7/2001 – 6/2011	**MSTP MD/PhD Combined Degree**, University of Washington, Seattle, WA. Ph.D. on the basic science of embryonic stem cells, specifically epigenetic regulation of differentiation Ph.D. conferred in June 2009. MD conferred in June 2011.
6/2011 – 6/2013	**Internal Medicine Residency**, University of Washington, Seattle, WA
6/2013 – 6/2017	**Infectious Diseases Fellowship**, University of Washington, Seattle, WA

Certifications and Licensure

Board Certifications

2014	Diplomate in Internal Medicine**,** American Board of Internal Medicine.
2016	Diplomate in Infectious Disease**,** American Board of Internal Medicine.

Current Medical Licenses to Practice

2013	Washington State Medical License, Physician, MD60394350
2018	Michigan State Medical License, Physician, 4301114297

Academic, Administrative, and Clinical Appointments

Academic

6/2014 – 6/2018	**Senior Fellow, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2016 – 6/2018	**Joel Meyers Endowment Fellow**, Vaccine and Infectious Disease Division, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Research Associate, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Acting Instructor**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Assistant Professor, Division of Infectious Diseases,** Department of Medicine, University of Michigan, Ann Arbor, MI

Clinical

12/2015 – 12/2016	**Infectious Disease Locums Physician**, Virginia Mason Medical Center, Seattle, WA
7/2017 – 6/2018	**Hospitalist Internal Medicine Physician**, Virginia Mason Medical Center, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Seattle Cancer Care Alliance, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Attending Physician,** Division of Infectious Diseases, Department of Medicine, University of Michigan, Ann Arbor, MI

Research Interests

1. I am primarily interested in understanding how the human gut microbiome *mechanistically* affects how patients respond to treatments. I have a particular focus on patients undergoing hematopoietic cell transplant, who are at risk for recurrence of their underlying disease, treatment-related colitis (from both conditioning and graft versus host disease), and infection. In human observational trials the human gut microbiome correlates with each of these aspects. My research program uses advanced stem-cell based *in-vitro* models of the human colonic mucosa to verify if the correlations in observational trials can cause similar effects *in vitro*, and then determine by which pathways (e.g. receptors) and broad mechanisms (e.g. epigenetics) the microbes affect the host.

2. Host-microbiome interactions are contextual. A beneficial interaction in health can turn pathologic. For example, my ongoing work focused on the microbial metabolite butyrate. Butyrate enhances the health of heathy and intact colonic epithelium, acting as a substrate for cellular respiration and through receptor-mediate processes reduces cellular inflammation. However, butyrate also blocks the ability of colonic stem cells to differentiate into mature epithelium. Thus, in colitis that results in a loss of colonic crypts, an intact and butyrogenic gut microbiome results in colonic stem cells being exposed to butyrate and inhibits recovery. My ongoing work uses a primary stem-cell based model of the human colonic mucusa to establish how butyrate blocks the differentiation of colonic stem cell with a hope of generating new treatments for patients with steroid-refractory colitis.

3. I am interested in validating and improving computational tools for biological research. I have a computer science and biomedical engineering background that combined with my clinical and molecular biology training positions me optimally to understand both major aspects of computational biology: what are the needs to make biological inferences from big data, and how can tools specifically be improved to achieve such inferences.

Grants

Present and Active

ASBMT New Investigator Award J. Golob (PI) 7/2018 – 7/2020
Hematopoietic Cell Transplant Outcomes and Microbial Metabolism
Role: PI
$30,000/yr for up to two years

NIH / NIAID R01 D. Fredricks (PI) 11/2017 – 11/2021
The Gut Microbiota and Graft versus Host Disease (GVHD), AI-134808
Role: Senior / key personnel
$823,701

NIH P01 T. Schmidt (PI) Pending / Reviewed
ENGINEERING MICROBIOMES AND THEIR MOLECULAR DETERMINANTS FOR PRODUCTION OF BUTYRATE AND SECONDARY BILE ACIDS FROM RESISTANT STARCH
Role: Key Personnel

NIH / NCI R21 J. Golob (PI) Pending / Submitted
Establishing a physiologic human colonic stem/progenitor cells model of regimen-related colitis
Role: PI

NIH R21 J. Golob (PI) Pending / Submitted
Manipulating Butyrate Production by the Gut Microbiome during Chronic HIV Infection
Role: PI

Completed

Joel Meyers Endowment Fellowship 6/2016 – 6/2018
Role: Research Fellow
$63,180

DCDR Grant R. Harrington (PI) 6/2014 – 6/2018
Support for data queries into the Deidentified Clinical Data Repository
Role: PI
$1000

NIH T32 Institutional Training Grant M. Boeckh (PI) 8/2016 – 8/2017
1T32AI118690-01A1
Role: Post-Doc Trainee
$315,972

NIH T32 Institutional Training Grant W. van Voorhis (PI) 7/1/14 – 6/30/16
5T32AI007044
Role: Post-Doc Trainee
$1,527,801

Honors and Awards

2001 Tau Beta Pi Engineering Honor Society
2001 Alpha Eta Mu Beta Biomedical Engineering Honor Society

2005 ARCS Fellowship
2015 Consultant of the Month Award. University of Washington Housestaff.
2016 Joel Meyer Endowment Fellow

Membership in Professional Societies

2013 Member, Infectious Diseases Society of America
2011 Member, American Board of Internal Medicine

Bibliography

Peer-Reviewed Journals and Publications

1. Gao Z, **Golob J,** Tanavde VM, Civin CI, Hawley RG, Cheng L. High levels of transgene expression following transduction of long-term NOD/SCID-repopulating human cells with a modified lentiviral vector. *Stem Cells* 19(3): 247-59, 2001.
2. Cui Y, **Golob J**, Kelleher E, Ye Z, Pardoll D, Cheng L. Targeting transgene expression to antigen-presenting cells derived from lentivirus-transduced engrafting human hematopoietic stem/progenitor cells. *Blood* 99(2): 399-408, 2002.
3. Boursalian TE, **Golob J**, Soper DM, Cooper CJ, Fink PJ. Continued maturation of thymic emigrants in the periphery. *Nature Immunology* 5(4): 418-25, 2004.
4. Osugi T, Kohn AD, **Golob JL**, Pabon L, Reinecke H, Moon RT, Murry CE. Biphasic role for Wnt/beta-catenin signaling in cardiac specification in zebrafish and embryonic stem cells. *PNAS* 104(23): 9685-9690, 2007.
5. **Golob JL**, Paige SL, Muskheli V, Pabon L, Murry CE: Chromatin Remodeling During Mouse and Human Embryonic Stem Cell Differentiation. *Developmental Dynamics* 237(5): 1389-1398, 2008.
6. **Golob JL**, Kumar RM, Guenther MG, Laurent LC, Pabon LM, Loring JF, Young RA, Murry CE: Evidence That Gene Activation and Silencing during Stem Cell Differentiation Requires a Transcriptionally Paused Intermediate State. *PLoS ONE* 6(8): e22416, 2011.
7. **Golob JL**, Margolis E, Hoffman NG, Fredricks DN. Evaluating the accuracy of amplicon-based microbiome computational pipelines on simulated human gut microbial communities. *BMC Bioinformatics* 18(1):283, 2017.
8. MacAllister TJ, Stednick Z, **Golob JL**, Huang, ML, Pergam SA. Under-utilization of norovirus testing in hematopoietic cell transplant recipients at a large cancer center. *Am J Infect Control* pii: S0196-6553(17)30783-6. doi: 10.1016/j.ajic.2017.06.010. [Epub ahead of print], 2017.
9. **Golob JL**, Pergam SA, Srinivasan S, Fiedler TL, Liu C, Garcia K, Mielcarek M, Ko D, Aker S, Marquis S, Loeffelholz T, Plantinga A, Wu MC, Celustka K, Morrison A, Woodfield M, Fredricks DN. The Stool Microbiota at Neutrophil Recovery is Predictive for Severe Acute Graft versus Host Disease after Hematopoietic Cell Transplantation. *Clin Infect Dis* doi: 10.1093/cid/cix699. [Epub ahead of print], 2017.
10. Bhattacharyya A, Hanafi LA, Sheih A, **Golob JL**, Srinivasan S, Boeckh MJ, Pergam SA, Mahmood S, Baker KK, Gooley TA, Milano F, Fredricks DN, Riddell SR, Turtle CJ. Graft-Derived Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Cell Transplantation. *Biol Blood Marrow Transplant* pii: S1083-8791(17)30758-9. doi: 10.1016/j.bbmt.2017.10.003. Epub 2017 Oct 9.
11. Ogimi C, Krantz EM, **Golob JL**, Waghmare A, Liu C, Leisenring WM, Woodard CR, Marquis S, Kuypers JM, Jerome KR, Pergam SA, Fredricks DN, Sorror ML, Englund JA, Boeckh M. Antibiotic Exposure Prior to Respiratory Viral Infection Is Associated with Progression to Lower Respiratory Tract Disease in Allogeneic Hematopoietic Cell

Transplant Recipients. Biol Blood Marrow Transplant. 2018 May 16. pii: S1083-8791(18)30268-4. doi: 10.1016/j.bbmt.2018.05.016. [Epub ahead of print]

12. **Golob JL**, Stern J, Holte S, Kitahata MM, Crane HM, Coombs RW, Goecker E, Woolfrey AE, Harrington RD. HIV DNA levels and decay in a cohort of 111 long-term virally suppressed patients. AIDS. 2018 Sep 24;32(15):2113-2118. doi: 10.1097/QAD.0000000000001948.
13. **Golob JL**, DeMeules MM, Loeffelholz T, Quinn ZZ, Dame MK, Silvestri SS, Wu MC, Schmidt TM, Fiedler TL, Hoostal MJ, Mielcarek M, Spence J, Pergam SA, Fredricks DN. Butyrogenic bacteria after acute graft-versus-host disease (GVHD) are associated with the development of steroid-refractory GVHD. Blood Adv. 2019 Oct 8;3(19):2866–2869.

Preprint publications

1. **Golob JL** and Minot SS. Functional Analysis of Metagenomes by Likelihood Inference (FAMLI) Successfully Compensates for Multi-Mapping Short Reads from Metagenomic Samples. Preprint. doi: https://doi.org/10.1101/295352

Other Publications

1. Science Columnist and Writer for *The Stranger*, Seattle, WA, 2004 – Present
2. Freelance contributor, Ars Technica, 2016 – Present.

Abstracts (presenter underlined)

1. **Golob JL,** Srinivasan S, Pergam SA, Liu C, Ko D, Aker S, Fredricks DN. Gut Microbiome Changes in Response to Protocolized Antibiotic Administration During Hematopoietic Cell Transplantation. ID Week, Infectious Diseases Society of America, October 2015 (Oral)
2. **Golob JL**, Stern J, Holte S, Kitahata M, Crane H, Coombs R, Goecker E, Woolfrey AE, Harrington RD. HIV reservoir size and decay in 114 individuals with suppressed plasma virus for at least seven years: correlation with age and not ARV regimen. IDWeek 2016, October 26-30, 2016, New Orleans. Abstract 953 (Oral).
3. **Golob JL** , Stohs E, Sweet A, Pergam SA, Boeckh M, Fredricks DN, and Liu C. Vancomycin is Frequently Administered to Hematopoietic Cell Transplant Recipients Without a Provider Documented Indication and Correlates with Microbiome Disruption and Adverse Events. ID Week, Infectious Diseases Society of America, October 2018 (# 72504).
4. Impact of Intestinal Microbiota on Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Stem Cell Transplantation. ASH 2018 (#3393).

Invited Lectures

1. Keynote Speaker, ARCS Foundation Annual Dinner. Seattle, WA Nov 3, 2008
2. Primary Care Conference: Direct to Consumer Genetic Testing, Seattle, WA, Mar 14, 2013
3. "IRIS and TB", Harborview Medical Center Housestaff Lunchtime Conference, Seattle, WA, Jun 9, 2014
4. "Complicated Enterococcal Endocarditis", University of Washington Medical Center (UWMC) Chief of Medicine Conference, Seattle, WA, Jul 14, 2014
5. "Coccidiomycosis", UWMC Chief of Medicine Conference, Seattle, WA, Oct 7, 2014
6. "HIV and CMV encephalitis", UWMC Chief of Medicine Conference, Seattle, WA, Apr 14, 2015
7. Research Presentation for GVHD Group Meeting, Seattle, WA, Nov 2015

8. "CMV Ventriculitis", Clinical Case Presentation to the Virology Working Group, Fred Hutchinson Cancer Research Center (Fred Hutch), Seattle, WA, Nov 2015
9. "Microbiome and HCT Outcomes". 1st Infectious Disease in the Immunocompromised Host Symposium – Tribute to Joel Meyers. Fred Hutch, Seattle, WA, Jun 13 2016.
10. "Microbiome and GVHD". Infectious Disease Sciences / Virology Symposium, Fred Hutch / UW, Seattle, WA, Jan 17 2017
11. "Microbiome and GVHD". 2nd Symposium on Infectious Disease in the Immunocompromised Host. June 19 2017
12. "The Gut Microbiome Predicts GVHD. Can It Be Engineered to Protect?". St Jude. February 18th 2019

Joseph J. Amon, PhD, MSPH

ROOM 734, NESBITT HALL
3215 MARKET ST
PHILADELPHIA, PA 19104
jja88@drexel.edu

EDUCATION

08/1998-10/2002	Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine *PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya*	Bethesda, MD
08/1991-12/1994	Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health & Tropical Medicine *MSPH, Tropical Medicine*	New Orleans, LA
08/1987-05/1991	Hampshire College *BA, Interdisciplinary Studies*	Amherst, MA

ACADEMIC APPOINTMENTS

9/2018 – Present	Dornsife School of Public Health, Drexel University *Director, Global Health* *Clinical Professor, Dept of Community Health and Prevention*	Philadelphia, PA
01/2010 – Present	Dept. of Epidemiology and Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins *Associate*	Baltimore, MD
09/2010 – 06/2018	Woodrow Wilson School of Public and International Affairs, Princeton University *Visiting Lecturer*	Princeton, NJ
01/2015 – 05/2018	Dept. of Epidemiology, Mailman School of Public Health, Columbia University *Adjunct Associate Professor*	New York, NY
06/2014 – 07/2014	School of Social Science, Institute for Advanced Study *Short-term Visitor*	Princeton, NJ
09/2012 – 12/2012	Institut d'Études Politiques de Paris (SciencesPo) *Distinguished Visiting Lecturer*	Paris, France
01/2003–06/2007	Dept. of Preventive Medicine, Hebert School of Medicine, Uniformed Services University of the Health Sciences *Adjunct Assistant Professor*	Bethesda, MD

TEACHING EXPERIENCE

Professor		
2019 - Present	Drexel University	Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate)
2011 – 2018	Princeton University	Health and Human Rights (undergraduate) Epidemiology (undergraduate)
09-12/2012	SciencesPo	Health and Human Rights (graduate)
Co-Instructor		
2012-2013	Global School of Socioeconomic Rights, Harvard University	Health Rights Litigation (graduate)

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

09/2019 – Present	Senior Editor, Health and Human Rights Journal
01/2010 – Present	Journal of the International AIDS Society, Editorial Board
07/2012 – Present	Journal of the International AIDS Society, Ethics Committee
01/2015 – 07/2016	Co-Editor, The Lancet HIV Special Issue on HIV and Prisoners
09/2017 – 06/2018	Co-Editor, Health and Human Rights Journal Special Issue on NTDs and Human Rights

Advisory

09/2016 – Present	The Global Fund, Working Group on Monitoring and Evaluating Programmes to Remove Human Rights Barriers to HIV, TB and Malaria Services
12/2014 – Present	UNAIDS, Strategic and Technical Advisory Group
07/2008 – Present	UNAIDS, HIV and Human Rights Reference Group (co-chair Aug 2014 – present)
06/2012 – 6/2018	Global Institute for Health and Human Rights, University at Albany, International Advisory Board
02/2012 – 01/2016	Founding member, Coalition for the Protection of Health Workers in Armed Conflict
01/2014 – 01/2016	Founding member: Robert Carr Award for Research on HIV and Human Rights
07/2011 – 07/2012	XIX International AIDS Conference, Scientific Programme Committee
11/2009 – 09/2012	WHO/STOP TB Partnership, TB and Human Rights Task Force

FULL-TIME WORK EXPERIENCE

09/2018-Present — **Drexel University, Dornsife School of Public Health,** *Philadelphia, PA.*
- *Director, Global Health*
- *Clinical Professor, Dept of Community Health and Prevention*

02/2016–08/2018 — **Helen Keller International,** *New York, NY.*
- *Vice President, Neglected Tropical Diseases*

Provided strategic, technical and overall management for >$125m portfolio of work on NTDs. Led development of proposals resulting in >$80m in new projects.

08/2005–01/2016 — **Human Rights Watch,** *New York, NY.*
- *Director, Health Division (Sept 2008 – Jan 2016)*
- *Founded Disability Rights Division (2013); Environment Division (2015)*
- *Director, HIV/AIDS Program (August 2005 – August 2008)*

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.

07/2003–06/2005 — **Centers for Disease Control and Prevention,** *Atlanta, GA.*
- *Epidemiologist, EIS Officer*

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.

07/2000–09/2002 — **Walter Reed Army Institute of Research,** *Silver Spring, MD.*
- *Research Fellow*

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.

07/1995–06/1998 — **Family Health International,** *Arlington, VA.*
- *Technical Officer (Jan – June 1998)*
- *Evaluation Officer (Aug 1996 – Dec 1997)*
- *Associate Evaluation Officer (July 1995 – July 1996)*

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.

09/1992–11/1994 — **U.S. Peace Corps,** *Lomé, Togo.*
- *Volunteer*

Designed and implemented process monitoring system for national Guinea Worm eradication program. Conducted health education training. Supervised village health workers.

SHORT-TERM AND CONSULTING EXPERIENCE

Human Rights Watch, *New York, NY.*	Provide technical review for research design, analysis and documents related to health and environment and human rights.	Sept 2018 – Present
The Futures Group International, *REACH Project, Washington DC.*	Co-investigator for HIV/AIDS operations research related to orphans and vulnerable children and adolescent-oriented HIV volunteer counseling and testing.	Mar 2002 – June 2003
Walter Reed Army Institute of Research, *Silver Spring, MD.*	Developed database and provided statistical support to malaria vaccine clinical trial project.	Apr 2002 – June 2003
John Snow, Inc., *Arlington, VA.*	Developed curriculum and provided training on HIV/AIDS monitoring and evaluation to Ministry of Health staff from 8 countries.	Dec. 2002 – June 2003
TvT Associates, *SYNERGY Project, Washington, DC.*	Designed $20+ million comprehensive HIV/AIDS strategy for USAID Ukraine and USAID Russia.	Dec. 2001 – April 2003
PACT, *Washington, DC.*	Designed outcome and impact evaluation of HIV behavioral intervention project.	June 2002
Encompass LLC, *Bethesda, MD.*	Designed evaluation of World Bank health sector reform training.	January – May 2002
U of Washington, *Center for Health Education and Research.*	Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.	April – May 2002
Family Health International, *Arlington, VA.*	Analyzed HIV-related behavioral surveillance results from studies in Honduras, Nigeria, Ghana, and Senegal.	Sept 1998 – Mar 2002
Datex Inc., *Falls Church, VA.*	Provided expert review for USAID-funded HIV/AIDS behavioral intervention grants competition.	May– Jun 2001 Jan – Feb 2000
PLAN International *Bamako, Mali and Arlington, VA.*	Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.	May – Dec 2000
Ministry of Health, *Kingston, Jamaica.*	Analyzed behavioral surveillance results and facilitated workshop examining HIV trends.	Oct 1998
Eli Lilly Foundation, *Diabetes Control Program, Accra, Ghana.*	Designed and implemented outcome and impact evaluation of diabetes prevention and care program.	Sept 1996
Carter Center, *Niger Guinea Worm Eradication Program, Zinder, Niger.*	Designed and implemented outcome and impact evaluation of guinea worm eradication program.	Mar – May 1995

PEER REVIEW JOURNAL PUBLICATIONS

1 Kotellos KA, **Amon JJ**, Githens Benazerga W. *Field Experiences: measuring capacity building efforts in HIV/AIDS prevention programmes.* AIDS 1998; 12 (supl 2):109-17.

2 Figueroa JP, Brathwaite AR, Wedderburn M, Ward E, Lewis-Bell K, **Amon JJ**, Williams Y, Williams E. *Is HIV/STD control in Jamaica making a difference?* AIDS 1998; 12 (supl 2):S89-S98.

3 Hayman JR, Hayes SF, **Amon J**, Nash TE. *Developmental expression of two spore wall proteins during maturation of the microsporidian Encephalitozoon intestinalis*. Infect Immun 2001; 69(11):7057-66.

4 **Amon JJ**. *Preventing HIV Infections in Children and Adolescents in Sub-Saharan Africa through Integrated Care and Support Activities.* African Journal on AIDS Research. 2002; 1(2):143-9.

5 Gourley IS, Kurtis JD, Kamoun M, **Amon JJ**, Duffy PE. *Profound bias in interferon-gamma and interleukin-6 allele frequencies in an area of western Kenya where severe malarial anemia is common in children.* Journal of Infectious Disease. 2002; 186(7):1007-12.

6 Wheeler C, Vogt T, Armstrong GL, Vaughan G, Weltman A, Nainan OV, Dato V, Xia G, Waller K, **Amon J**, Lee TM, Highbaugh-Battle A, Hembree C, Evenson S, Ruta MA, Williams IT, Fiore AE, Bell BP. *A Foodborne Outbreak of Hepatitis A in Pennsylvania Associated with Green Onions*. New England Journal of Medicine 2005, 353(9):890-7.

7 **Amon JJ**, Nedsuwan S, Chantra S, Bell BP, Dowell SF, Olsen SJ, Wasley A. *Trends in Liver Cancer, Sa Kaeo Province, Thailand.* Asian Pacific Journal of Cancer Prevention 2005, 6(3):382-6.

8 **Amon JJ,** Devasia R, Xia G, Nainan OV, Hall S, Lawson B, Wolthuis JS, Macdonald PD, Shepard CW, Williams IT, Armstrong GL, Gabel JA, Erwin P, Sheeler L, Kuhnert W, Patel P, Vaughan G, Weltman A, Craig AS, Bell BP, Fiore A. *Molecular Epidemiology of Foodborne Hepatitis A Outbreaks in the United States, 2003*. Journal of Infectious Disease. 2005 Oct 15;192(8):1323-30.

9 **Amon JJ,** Drobeniuc J, Bower W, Magaña JC, Escobedo MA, Williams IT, Bell BP, Armstrong GL. *Locally Acquired Hepatitis E Virus Infection, El Paso, TX.* Journal of Medical Virology 2006, 78(6):741-6.

10 **Amon JJ,** Darling N, Fiore AE, Bell BP, Barker LE. *Factors Associated with Hepatitis A Vaccination among Children 24-35 Months in the U.S., 2003.* Pediatrics 2006, 117(1):30-3.

11 Ryan JR, Stoute JA, **Amon J,** Dunton RF, Mtalib R, Koros J, Owour B, Luckhart S, Wirtz RA, Barnwell JW, Rosenberg R. *Evidence for Transmission of Plasmodium Vivax among a Duffy Antigen Negative Population in Western Kenya.* American Journal of Tropical Medicine and Hygiene. 2006 75(4):575-81.

12 Kippenberg J, Baptiste J, **Amon JJ**. *Detention of Insolvent Patients in Burundian Hospitals.* Health Policy and Planning. 2008; Jan;23(1):14-23.

13 **Amon JJ.** *Dangerous Medicines: Unproven AIDS Cures and Counterfeit Antiretroviral Drugs.* Globalization and Health. 2008; Feb 27;4:5.

14 **Amon JJ**, Garfein R, Adieh-Grant L, Armstrong GL, Ouellet LJ, Latka MH, Vlahov D, Strathdee SA, Hudson SM, Kerndt P, Des Jarlais D, Williams IT. *Prevalence of HCV infection among injecting drug users in 4 U.S. cities at 3 time periods, 1994 – 2004.* Clinical Infectious Diseases. 2008, Jun 15;46(12):1852-8.

15 Cohen JE and **Amon JJ**. *Health and human rights concerns of drug user in detention in Guangxi, China.* PLoS Medicine. 2008, Dec 9;5(12):e234.

16 **Amon JJ** and Todrys K. *Fear of Foreigners: HIV-related restrictions on entry, stay, and residence.* Journal of the International AIDS Society. 2008, Dec 16;11:8..

17 **Amon JJ** and Kasambala T. *Structural Barriers and Human Rights Related to HIV Prevention and Treatment in Zimbabwe.* Global Public Health. 2009, Mar 26:1-17.

18 **Amon JJ** and Todrys K. *Access to Antiretroviral Treatment for Migrant Populations in the Global South*. SUR: International Journal on Human Rights. 2009, 6 (10), 162-187.

19 Todrys K. and **Amon JJ**. *Within but Without: Human Rights and Access to HIV Prevention and Treatment for Internal Migrants*. Globalization and Health. 2009, 5, 17.

20 Hafkin J, Gammino VM, **Amon JJ**. *Drug Resistant Tuberculosis in Sub-Saharan Africa.* Current Infectious Disease Reports 2010, 12(1), 36-45.

21 Lohman D, Schleifer R, **Amon JJ**. *Access to Pain Treatment as a Human Right.* BMC Medicine. 2010 Jan 20;8(1):8.

22 Jurgens R, Csete J, **Amon JJ**, Baral S, Beyrer C. *People who use drugs, HIV, and human rights.* Lancet 2010 Aug 7;376(9739):475-85.

23 Thomas L, Lohman D, **Amon J**. *Access to pain treatment and palliative care: A human rights analysis.* Temple International and Comparative Law Journal. Spring 2010. 24, 365

24 Todrys K*, **Amon JJ*,** Malembeka G, Clayton M. *Imprisoned and imperiled: access to HIV and TB prevention and treatment, and denial of human rights, in Zambian prisons.* Journal of the International AIDS Society 2011, 14:8. (*co-first authors)

25 Todrys K, **Amon JJ.** *Health and human rights of women imprisoned in Zambia.* BMC International Health and Human Rights 2011, 11:8.

26 Todrys K, **Amon JJ.** *Human rights and health among juvenile prisoners in Zambia.* International Journal of Prisoner Health, 2011, 7(1):10-17.

27 Barr D, **Amon JJ**, Clayton M. *Articulating a rights-based approach to HIV treatment and prevention interventions.* Current HIV Research, 2011, 9, 396-404.

28 Granich R, Gupta S, Suthar AB, et al. (**Amon J**, as member of the ART in Prevention of HIV and TB Research Writing Group) *Antiretroviral therapy in prevention of HIV and TB: update on current research efforts.* Current HIV Research, 2011 9, 446-69.

29 Jones L, Akugizibwe P, Clayton M, **Amon JJ**, Sabin ML, Bennett R, Stegling C, Baggaley R, Kahn JG, Holmes CB, Garg N, Obermeyer CM, Mack CD, Williams P, Smyth C, Vitoria M, Crowley S, Williams B, McClure C, Granich R, Hirnschall G. *Costing human rights interventions as a part of universal access to HIV treatment and care in a Southern African setting.* Current HIV Research, 2011, 9, 416-428.

30 Todrys KW, **Amon JJ**. *Criminal Justice Reform as HIV and TB Prevention in African Prisons.* PLoS Medicine, 2012, 9(5): e1001215.

31 Biehl J, **Amon JJ,** Socal MP, Petryna A. *Between the court and the clinic: Lawsuits for medicines and the right to health in Brazil.* Health and Human Rights Journal. June 2012, 12(6).

32 **Amon JJ**, Beyrer C, Baral S., Kass N. *Human Rights Research and Ethics Review: Protecting Individuals or Protecting the State?* PLoS Med 9(10): e1001325. Oct 2012

33 Dekker AM, **Amon JJ**, le Roux KW, Gaunt CB. *What is Killing Me Most: Chronic Pain and the Need for Palliative Care in Eastern Cape, South Africa*. Journal of Pain and Palliative Care Pharmacotherapy. 2012;26:1–7.

34 **Amon JJ**, Buchanan J, Cohen J, Kippenberg J. *Child Labor and Environmental Health: Government Obligations and Human Rights*. International Journal Pediatrics. 2012, #938306

35 Cohen JE, **Amon JJ.** *China's Lead Poisoning Crisis.* Health and Human Rights Journal. 2012: Dec 15;14(2):74-86

36 Todrys KW, Howe E, **Amon JJ**. *Failing Siracusa: Governments' Obligations to Find the Least Restrictive Options for Tuberculosis Control.* Public Health Action. 2013: 3(1):7-10.

37 **Amon JJ**, Schleifer R, Pearshouse R, Cohen JE. *Compulsory Drug Detention Centers in China, Cambodia, Vietnam and Lao PDR: Health and Human Rights Abuses.* Health and Human Rights Journal. December 2013.

38 **Amon JJ**, Schleifer R, Pearshouse R, Cohen JE. *Compulsory Drug Detention in East and Southeast Asia: Evolving Government, UN and Donor Responses*. International Journal of Drug Policy 2014: 25(1):13-20.

39 Denholm JT, **Amon JJ**, O'Brien R et al. *Attitudes towards involuntary incarceration for tuberculosis: a survey of Union members.* International Journal of Tuberculosis and Lung Disease 2014: 18(2):155-9.

40 **Amon JJ,** Wurth M, McLemore M. *Evaluating Human Rights Advocacy: A Case Study on Criminal Justice, HIV and Sex Work.* Health and Human Rights Journal 17/1. March 2015.

41 Lohman D, **Amon JJ.** *Evaluating a Human Rights-Based Advocacy Approach to Expanding Access to Pain Medicines and Palliative Care: Global Advocacy and Case Studies from India, Kenya, and Ukraine.* Health and Human Rights Journal 17/2. Dec 2015.

42 Meier BM, Gelpi A, Kavanagh MM, Forman L, **Amon JJ**. *Employing Human Rights Frameworks to Realize Access to an HIV Cure.* J Int AIDS Soc. 18(1):20305.

43 Biehl J, Socal M, **Amon JJ**. *The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil.* Health and Human Rights Journal 18/1. June 2016.

44 Rich JD, Beckwith CG, Macmadu A, Marshall BD, Brinkley-Rubinstein L, **Amon JJ**, Milloy MJ, King MR, Sanchez J, Atwoli L, Altice FL. *Clinical care of incarcerated people with HIV, viral hepatitis, or tuberculosis.* The Lancet. 2016 Jul 14.

45 Dolan K, Wirtz AL, Moazen B, Ndeffombah M, Galvani A, Kinner SA, Courtney R, McKee M, **Amon JJ**, Maher L, Hellard M. *Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees.* The Lancet. 2016 Jul 14.

46 Rubenstein LS, **Amon JJ**, McLemore M, Eba P, Dolan K, Lines R, Beyrer C. *HIV, prisoners, and human rights.* The Lancet. 2016 Jul 14.

47 Telisinghe L, Charalambous S, Topp SM, Herce ME, Hoffmann CJ, Barron P, Schouten EJ, Jahn A, Zachariah R, Harries AD, Beyrer C, **Amon JJ**. *HIV and tuberculosis in prisons in sub-Saharan Africa.* The Lancet. 2016 Jul 14.

48 Beletsky L, Arredondo J, Werb D, Vera A, Abramovitz D, **Amon JJ**, Brouwer KC, Strathdee SA, Gaines TL. *Utilization of Google enterprise tools to georeference survey data among hard-to-reach groups: strategic application in international settings*. International Journal of Health Geographics. 2016 Jul 28;15(1):24.

49 Doyle KE, El Nakib SK, Rajagopal MR, S Babu, G Joshi, V Kumarasamy, P Kumari, P Chaudhri, S Mohanthy, D Jatua, D Lohman, **Amon JJ**, G Palat. *Predictors and prevalence of pain and its management in four regional cancer hospitals in India.* Journal of Global Oncology. (2017): JGO-2016.

50 Hamdi H, Ba O, Niang S, Ntizimira C, Mbengue M, Coulbary AS, Niang R, Parsons M, **Amon JJ**, Lohman D. *Palliative Care Need and Availability in Four Referral Hospitals in Senegal: Results from a Multi-Component Assessment.* Journal of Pain and Symptom Management. 2017 Dec 7.

51 Traoré L, Dembele B, Keita M, Reid S, Dembéle M, Mariko B, Coulibaly F, Goldman W, Traoré D, Coulibaly D, Guindo B, **Amon JJ**, Knieriemen M, Zhang Y. *Prevalence of trachoma in the Kayes region of Mali eight years after stopping mass drug administration.* PLoS neglected tropical diseases. Feb 2018;12(2):e0006289.

52 Biehl J, Socal MP, Gauri V, Diniz D, Medeiros M, Rondon G, **Amon JJ**. *Judicialization 2.0: Understanding right-to-health litigation in real time.* Global Public Health. May 2018 22:1-0.

53 Sun N and **Amon JJ**. *Addressing Inequity: Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

54 **Amon JJ**, Addiss D. *"Equipping Practitioners": Linking Neglected Tropical Diseases and Human Rights.* Health and Human Rights Journal. June 2018.

55 Géopogui A, Badila CF, Baldé MS, Nieba C, Lamah L, Reid SD, Yattara ML, Tougoue JJ, Ngondi J, Bamba IF, **Amon JJ**. Baseline trachoma prevalence in Guinea: Results of national trachoma mapping in 31 health districts. PLoS neglected tropical diseases. June 2018; 12(6):e0006585.

56 Coltart CE, Hoppe A, Parker M, Dawson L, **Amon JJ**, Simwinga M, Geller G, Henderson G, Laeyendecker O, Tucker JD, Eba P. Ethical considerations in global HIV phylogenetic research. The Lancet HIV. Aug 2018

57 **Amon JJ**, Eba P, Sprague L, Edwards O, Beyrer C. Defining rights-based indicators for HIV epidemic transition. PLoS medicine. Dec 2018; 15(12):e1002720.

58 Bah YM, Bah MS, Paye J, Conteh A, Saffa S, Tia A, Sonnie M, Veinoglou A, **Amon JJ**, Hodges MH, Zhang Y. *Soil-transmitted helminth infection in school age children in Sierra Leone after a decade of preventive chemotherapy interventions.* Infectious diseases of poverty. 2019 Dec;8(1):41.

59 Addiss DG, **Amon JJ**. *Apology and Unintended Harm in Global Health.* Health and Human Rights. 2019 Jun;21(1):19.

60 Socal MP, **Amon JJ**, Biehl J. *Institutional Determinants of Right-to-Health Litigation: The Role of Public Legal Services on Access to Medicines in Brazil.* Global Public Health. (in press)

61 Ward E, Hannass-Hancock J, **Amon JJ**. *Invisible: The Exclusion of Persons with Disabilities from HIV Research and National Strategic Plans in East and Southern Africa.* (Article: submitted)

BOOK CHAPTERS

1 **Amon J**. *Africa, Southern* in: Encyclopedia of AIDS, Ray Smith, ed. Chicago: Fitzroy Dearborn Publishers, 1998.

2 **Amon JJ**, Kotellos KA, Githens Benazerga W. *Evaluating Capacity Building*. HIV/AIDS Prevention and Control Synopsis Series. Family Health International, Arlington, VA: 1997.

3 **Amon JJ,** Saidel TJ, Mills S. *Behavioral Surveillance Survey Methodology: Experiences from Senegal and India.* WHO/UNAIDS Best Practices Series. WHO/UNAIDS. Geneva, June 2000.

4 **Amon J**, Brown T, Hogle J, MacNeil J, et al. *Behavioral Surveillance Surveys: Guidelines for repeated behavioral surveys in populations at risk of HIV*. FHI/IMPACT, USAID, DFID Publication. August 2000.

5 Kolars-Sow C, Saidel T, Hogle J, **Amon J**, Mills S. Indicators and questionnaires for behavioral surveys. In: Rehle T, Saidel T, Mills S, and Magnani R., (eds.) Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers. Family Health International, Arlington, VA. August 2001.

6 **Amon JJ**, Bond KC, Brahmbhatt MN, *et al*. *Bellagio Principles on Social Justice and Influenza.* Johns Hopkins. Berman Institute of Bioethics. July 2006.

7 Cohen J. and **Amon J**. Governance, Human Rights and Infectious Disease: Theoretical, Empirical and Practical Perspectives. in: K.H. Mayer and H. F. Pizer, (eds.) Social Ecology of Infectious Diseases. New York: Academic Press. December 2007.

8 **Amon J**. *High Hurdles for Health.* In: M. Worden (ed.) China's Great Leap: The Beijing Games and Olympian Human Rights Challenges. Seven Stories Press. May 2008.

9 **Amon J.** *Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights.* In: N. Sudarshan (ed.) HIV/AIDS, Health Care and Human Rights Approaches. Amicus Books. Jan 2009.

10 **Amon J.** *Abusing Patients.* In: Human Rights Watch, 2010 World Report. New York: Seven Stories Press. Jan 2010.

11 **Amon JJ** and Kasambala T. Structural barriers and human rights related to HIV prevention and treatment in Zimbabwe. In: M. Seglid and T. Pogge (eds) Health Rights. London: Ashgate. Oct 2010.

12 **Amon JJ.** *HIV and the Right to Know: Whose right to know what? The discourse of human rights in the global HIV response*. In: J. Biehl and A. Petryna (eds.) "When people come first: Anthropology and social innovation in global health". Princeton: Princeton University Press. July 2013.

13 **Amon JJ.** *Health Security and/or Human Rights?* In: S Rushton and J Youde (eds) "Routledge Handbook of Health Security". New York: Routeledge. August 2014.

14 **Amon JJ** and Friedman E. *Human Rights Advocacy for Global Health*. In: LO Gostin and BM Meier (eds) "Foundations of Global Health & Human Rights". New York: Oxford University Press. 2020

EDITORIAL/COMMENT

1 **Amon J**. *The Continued Challenge Posed by HIV-Related Restrictions on Entry, Stay, and Residence.* HIV/AIDS Policy and Law Review. 2008, 13(2/3).

2 Biehl J, Petryna A, Gertner A, **Amon JJ**, Picon PD. *Judicialization of the Right to Health in Brazil*. Lancet. 2009, 373(9682):2182-4.

3 **Amon JJ**, Girard F, Keshavjee S. *Limitations on human rights in the context of drug-resistant tuberculosis: A reply to Boggio et al.* Health and Human Rights. 2009, 11(1).

4 Thomas L, Lohman D, **Amon J**. *Doctors take on the state: championing patients' right to pain treatment.* Int J Clin Pract. 2010, 64(12):1599-600.

5 **Amon J.** *HIV Treatment as Prevention – Human Rights Issues.* Journal of the International AIDS Society. 2010, 13(Suppl 4):O15

6 **Amon JJ**. *Hepatitis in Drug Users: Time for Attention, Time for Action.* Lancet, 2011, 378(9791):543-4

7 **Amon J**, Lohman D. *Denial of Pain Treatment and the Prohibition of Torture, Cruel, Inhuman or Degrading Treatment or Punishment.* Interrights Bulletin, 2011, Vol 16: 4.

8 **Amon J**. *Justice Delayed, Health Denied*. The Scientist. June, 2012.

9 Kyoma M, Todrys KW, **Amon JJ**. *Laws against sodomy and the HIV epidemic in African prisons.* Lancet, 2012, *380 (9839): 310 - 312*

10 Pearshouse R, **Amon JJ**. *The Ethics of Research in Compulsory Drug Detention Centers in Asia.* Journal of the International AIDS Society. 2012, 15:18491

11 Wurth MH, Schleifer R, McLemore M, Todrys KW, **Amon JJ**. *Condoms as Evidence of Prostitution in the US and the Criminalization of Sex Work.* Journal of the International AIDS Society. 16(1): 10.7448/IAS.16.1.18626.

12 **Amon JJ.** *Political Epidemiology of HIV.* Journal of the International AIDS Society. 2014, 17:19327

13 **Amon JJ.** *Law, Human Rights and Health Databases: A roundtable discussion.* Health and Human Rights Journal. September 2014.

14 Otremba M, Berland G, **Amon JJ.** *Hospitals as Debtor Prisons.* The Lancet Global Health. 3, 5: e253–e254, May 2015.

15 Beyrer C, Kamarulzaman A, McKee M, for the Lancet HIV in Prisoners Group (incl. **Amon JJ**). *Prisoners, prisons, and HIV: time for reform.* The Lancet. 2016 Jul 14.

16 **Amon JJ**. *The impact of climate change and population mobility on neglected tropical disease elimination*. International Journal of Infectious Diseases 53 (2016): 12.

17 **Amon JJ.** *WHO Focus on Human Rights: Will it Extend to Neglected Tropical Diseases?* Health and Human Rights Journal. Nov 2017.

18 Groves, A, Maman S, Stankard PH, Gebrekristos LT, **Amon JJ,** Moodley D. *Addressing the unique needs of adolescent mothers in the fight against HIV*. Journal of the International AIDS Society.

19 **Amon JJ**, Sun N. *Subverting Rights: Addressing the Increasing Barriers to Reproductive Rights.* Health and Human Rights Journal. May 2018.

20 Biehl J, **Amon JJ**. *The Right to Remedies: On Human Rights Critiques and Peoples' Recourses.* Humanity Journal. Oct 2019

21 Williams C, **Amon JJ**, Bassett MT, Roux AV, Farmer PE. *25 Years: Exploring the Health and Human Rights Journey*. Health and Human Rights. 2019 Dec;21(2):279.

22 **Amon JJ**, Sun N. *HIV, human rights and the last mile.* Journal of the International AIDS Society. 2019 Dec 1;22(12).

23 **Amon JJ**. *Ending discrimination in healthcare.* Journal of the International AIDS Society. 2020 Feb;23(2).

LETTERS

1 **Amon JJ.** *The HIV/AIDS Epidemic in Ukraine: stable or still exploding?* Sexually Transmitted Infections. 2003 79(3):263-4.

2 Lohman D, **Amon JJ**. *HIV Testing*. Lancet. 2008 Feb 16;371(9612):557-8.

3 Root B, Levine I, **Amon JJ**. *Counting and Accountability*. Lancet. 2008 Jan 12;371(9607):113.

4 Tarantola D, **Amon J**, Zwi A, Gruskin S, Gostin L. *H1N1, public health security, bioethics, and human rights.* Lancet. 2009 Jun 20;373(9681):2107-8

5 Hsieh A, **Amon JJ**. *Ratification of human rights treaties: the beginning not the end.* Lancet. 2009 Aug 8;374(9688):447

6 **Amon J**, Lohman D, Thomas L. *Access to pain treatment a luxury for most.* Lancet 2009 Nov 14; 374:1676

7 **Amon J**. *Harm reduction and the Catholic Church.* Conscience. Winter 2010.

8 **Amon J.** *Human Rights Abuses, Ethics, and the Protection of Subjects When Conducting Research on Intravenous Drug Users in China.* JAIDS: Journal of Acquired Immune Deficiency Syndromes. June 2011.

9 Cohen EJ, **Amon JJ**. *Lead Poisoning in China.* Lancet, 2011, 378(9803):e3.

10 **Amon JJ.** *Chinese Addiction Study and Human Rights.* Science, 2012, 337:522-523.

11 Pearshouse R and **Amon JJ.** *Human Rights and HIV Interventions in Chinese Labour Camps.* Sex Transm Infect. doi:10.1136/sextrans-2015-052193

12 Biehl J, **Amon JJ**, Socal M, Petryna A. *The Challenging Nature of Gathering Evidence and Analyzing the Judicialization of Health in Brazil.* Cadernos de Saúde Pública. July 2016.

13 Biehl J, Socal M, **Amon JJ**. *On the Heterogeneity and Politics of the Judicialization of Health in Brazil.* Health and Human Rights Journal. Dec 2016.

14 **Amon J**. *Re: Attacks on Ebola Health Workers in the Democratic Republic of Congo.* New York Times. May 23, 2019.

15 Rubenstein L, **Amon JJ.** *Global health, human rights, and the law.* The Lancet. 2019 Nov 30;394(10213):1987-8.

OPINION

1 Empowering Women and Realizing Rights. *Toronto Star.* August 11, 2006

2 Why We Need an International AIDS Conference. *Toronto Globe and Mail.* August 15, 2006

3 Curb HIV infection rates in Texas prisons. *Austin American Statesman.* May 10, 2007

4 Diagnosis and Prescriptions. *Foreign Affairs.* May/June 2007

5 The Bush Policy On AIDS. *Huffington Post.* July 26, 2007

6 Saudi Move on HIV/AIDS will make the epidemic worse. *Saudi Debate.* Oct 24, 2007

7 How not to fight HIV/Aids. *The Guardian.* Jan 28, 2008

8 Blaming Foreigners. *The Korea Times.* March 12, 2009

9 Progress against HIV at risk. *Phnom Penh Post.* November 16, 2009

10 HIV Travel Bans: Small Steps, Big Gaps. *Huffington Post.* January 11, 2010

11 Don't Improve Drug Detention: End It. *Huffington Post.* January 15, 2010

12 Torture in health care. *Huffington Post.* January 22, 2010

13 Treatment or punishment? *Bangkok Post.* January 24, 2010

14 Rights abuses threaten HIV risk. *Phnom Penh Post.* January 27, 2010

15 Cambodian drug rehab centers: Abusive, illegal, ineffective. *The Nation (Bangkok).* Jan 27 2010

16 Drug dependence is not a moral issue. *Phnom Penh Post.* January 29, 2010

17 Condoms and Bibles. *The National (PNG)*. February 8, 2010

18 Chronic Pain and Torture. *Huffington Post.* February 23, 2010

19 Invisible Women. *Huffington Post.* March 8, 2010

20 How Not to Protect Children. *Phnom Penh Post.* March 8, 2010

21 Choam Chao needs independent investigation. *Phnom Penh Post.* March 24, 2010

22 March 24 Is World Tuberculosis Day. *Huffington Post.* March 24, 2010
23 Who Will Defend Children in Cambodian Drug Rehab Centres? *The Nation.* March 31, 2010
24 Holiday in Cambodia? *Huffington Post.* April 6, 2010
25 When the Government Sponsors Stigma. *Huffington Post.* April 27, 2010 (with M. McLemore)
26 Zambia's TB-ridden prisons. *The Guardian*. April 27, 2010
27 Chinese Corruption Is Hazardous to Your Health. *Asia Wall Street Journal*. May 13, 2010
28 Why the Vietnamese Don't Want to Go to Rehab. *Foreign Policy.* May 28, 2010
29 Aids and TB are breaking out of prisons. *East African*. June 7, 2010
30 Uganda AIDS Policy: from Exemplary to Ineffective. *The Observer* (Kampala) June 24, 2010
31 When a Problem Comes Along, You Must Whip It. *Huffington Post*. June 26, 2010
32 Action not Rhetoric on HIV and Human Rights. *Huffington Post.* July 2, 2010
33 The Truth About China's Response to HIV/AIDS. *Los Angeles Times*. July 11, 2010
34 HIV Behind Bars. *The Post* (Lusaka). July 11, 2010
35 HIV and Human Rights: Here and Now? *Huffington Post*. July 19, 2010
36 The HIV and TB Prison Crisis in Southern Africa. *Huffington Post*. July 23, 2010
37 Jailing TB patients not remedy for the disease. *The Star* (Nairobi). Sept 17, 2010
38 Rights and Health, Right Now, for Migrants. *Africa Now (Tokyo).* October 2010 (with Kanae Doi)
39 Why Democracies Don't Get Cholera. *Foreign Policy.* October 25, 2010.
40 The Beginning of the End for the War on Drugs? *San Francisco Chronicle.* November 21, 2010
41 Rights Abuses Belie Success in AIDS Fight. *South China Morning Post.* December 1, 2010
42 World AIDS Day: Prevention, Treatment for Prisoners. *Zambia Post.* December 1, 2010
43 Lead poisoning in Nigeria: unprecedented. *Global Post.* December 2, 2010
44 China is hurting its future by not acting on lead. *South China Morning Post.* June 20, 2011
45 Hard life in Ugandan prisons. *The Independent (Uganda).* July 8. 2011
46 'Utterly Irresponsible': Donor Funding in Drug 'Treatment' Centers. *Huff. Post.* Sept 14, 2011
47 National Cashew Day: More Than Nuts. *Global Post.* October 3, 2011
48 A centre for abuse and beating. *The Nation* (Bangkok). October 11, 2011
49 Laos' Murky War on Drugs. *The Diplomat.* October 12, 2011
50 One AIDS march that should end. *Washington Blade.* October 28, 2011
51 Seoul's Broken Promises on HIV Testing. *The Diplomat.* June 29, 2013
52 Drug treatment centres give more abuse than therapy. *Bangkok Post*. December 18, 2013
53 Enlightened drug policies emerge globally, Cambodia remains rigid**.** *Global Post.* Jan 9, 2014
54 Health Under Attack. HRW Dispatch. May 19, 2014 (with Jennifer Pierre)
55 Canada's prostitution bill a step in the wrong direction. *Ottawa Citizen.* June 18, 2014
55 In The HIV Response, Who is 'Hard to Reach'? HRW Dispatch. July 23, 2014
56 Defeating AIDS. HRW Dispatch. June 30, 2015
57 How not to handle Ebola. CNN. September 12, 2014

58 Taking Care of the Caregivers. HRW Dispatch. December 17, 2014

59 Alert in a Time of Cholera. HRW Dispatch. March 26, 2015

60 Stop Using Hospitals as Debtor Prisons. HRW Dispatch. April 14, 2015

61 COP21: The Impact of Climate Change on the World's Marginalized Populations: Turkana County, Kenya. Health and Human Rights Journal Blog. October 27, 2015. (with Katharina Rall)

62 An Important, but Imperfect, Agreement by an Unprecedented Coalition. *US News and World Report.* December 18, 2015

63 Health workers are under attack around the world. Here's how bad it's getting. *Philadelphia Inquirer.* May 28, 2019. (with Jennifer Taylor)

INVITED PRESENTATIONS (SELECT)

1 *Surveillance design and evaluation approach of the Togo Guinea Worm Eradication Program.* III West African Guinea Worm Eradication Conference, Abidjan, Cote d'Ivoire, November 1993.

2 *Knowledge, attitudes and behaviors related to Guinea Worm Eradication, Togo.* IV West African Guinea Worm Eradication Conference, Ouagadougou, Burkina Faso, October 1994.

3 *Synthesis of evaluation results from the AIDSCAP project: 1992-1996.* HIV/STD/AIDS National Forum, Port-au-Prince, Haiti, June 3-5, 1996. Research and Evaluation Panel Chair.

4 *International Trends in HIV-Risk Related Behavior Change.* National Conference on HIV/AIDS, Kingston, Jamaica, November 25-26, 1996.

5 *HIV/AIDS and Adolescents in Ukraine.* Ukrainian-American Medical Society Annual Meeting. Philadelphia, PA, May 2003.

6 *Expanding HIV testing and respecting rights.* International conference on HIV/AIDS and Human Rights. Smolny College. St Petersburg, Russia. October 2005.

7 *HIV in Conflict Settings*. Joint Congressional Human Rights Caucus meeting. Washington DC. March 2006.

8 *Reflections and recollections.* Masters Internationalist - US Peace Corps Symposium. Washington DC. April 2006. (Keynote)

9 *Civil Society Participation in the Response to HIV/AIDS and Accountability.* Presented in panel 1: Breaking the cycle of infection for sustainable AIDS responses. United Nations General Assembly Special Session on HIV/AIDS. New York. June 2006.

10 *HIV testing and human rights.* Public Health Agency of Canada Meeting on HIV Testing. Toronto. August 2006.

11 *Hot Topics in Human Rights*. XVI International AIDS Conference. Toronto. August 2006.

12 *Burma, HIV and Human Rights.* Asia Society. New York. September 2007.

13 *HIV and Youth*. 12th Annual Herbert Rubin and Justice Rose Luttan Rubin International Law Symposium. New York University. New York. October 2007.

14 *HIV testing: human rights considerations*. Funders Network on Population, Reproductive Health and Rights. Annual Meeting, San Antonio, TX. October 2007.

15 *Human Rights and Epidemic Disease: TB control and constraints on rights.* Human Rights Funders Group. Annual Meeting. New York, NY. July 2008.

16 *Promoting Public Health and Human Rights in MDR-TB Care.* International Union against Lung and Tuberculosis Disease. Paris, France. October 2008.

17 *Public Health and Human Rights: Challenges around the World.* New York Academy of Sciences and Johns Hopkins School of Public Health Conference on Public Health and Human Rights. New York, NY. Dec 2008.

18 *Human Rights and Anti-Narcotics Policy.* UN General Assembly, Special Session on Drugs. Vienna, Austria. March 2009.

19 *Rights-based approaches to health.* Interaction Annual Meeting. Arlington, VA. July 2009. (panel moderator)

20 *Health and Human Rights: New orthodoxies and on-going conflicts in repressive states.* Stanford University, Palo Alto, CA. October 2010.

21 *HIV in Asia.* Asia Society. December 1, 2010.

22 *HIV Rights and Wrongs.* GlobeMed National Conference. Northwestern University, Chicago, IL. April 2011. (Keynote)

23 *Human Rights Perspective.* International Workshop on Treatment as Prevention. Vancouver, Canada. May 2011.

24 *Sustaining Environmental, Occupational and Public Health and Community Security: Lead Poisoning in China and Nigeria.* 12th National Conference on Science, Policy and the Environment. Washington, DC. January 2012.

25 *Health and Human Rights in Prisons.* European Infectious Disease meeting. Italy. September 2012. (Keynote)

26 *Measuring Violence against Children and the Effectiveness of Violence Prevention and Reduction Initiatives.* Columbia University. October 2013. (Panel Discussion Moderator)

27 *Political Epidemiology of HIV.* HIV 2014: Science, Community and Policy for Key Vulnerable Populations. New York Academy of Sciences. May 2014.

28 *On the Radar: Police Brutality, Politics & Public Health.* Princeton University. March 2015.

29 *Global Inequalities of Wealth and Health.* Bernstein Institute for Human Rights Annual Conference. New York University School of Law. April 2015.

30 *Environmental and occupational health and human rights.* Health and Human Rights Principles and Pedagogy. Florence, Italy. June 2015.

31 *Interviewing Victims of Human Rights Abuses.* Buzzfeed. New York. June 2015.

32 *Global Health and Governance.* Brookings Institution. May 2016.

33 *Access to pain medicine and human rights.* O'Neill Institute Health Rights Litigation. June 2016

33 *The Morbidity Management and Disability Prevention Project.* Global Alliance for Elimination of Trachoma 2020. Geneva, Switzerland. April 2017.

34 *Human Rights and Phylogenetic Analysis.* Ethics of Phylogenetics. Gates Foundation, UNAIDS, National Institutes for Health. London, UK. May 2017.

35 *Judicialization and access to medicines in Brazil.* O'Neill Institute Health Rights Litigation. Washington DC. June 2016.

36 *Implementing health related SDGs through a human rights perspective.* United Nations Social Forum. Geneva. October 2017.

37 *Indicators, Equity, Rights*. Making the end of AIDS real: Consensus building around what we mean by "epidemic control". Glion, Switzerland. October 2017.

CONFERENCE PRESENTATIONS

1 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among male STD clinic attendees in Jamaica.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

2 **Amon J**, Bolanos L, Gonzales MT, Zelaya A, Lopez C, Rodriguez J. *Knowledge of, availability, and use of condoms among commercial sex workers in four cities in Honduras.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

3 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among youth aged 12-14 in Jamaica.* XII Int Conf AIDS. 1998; 12:191 (abstract no. 13527).

4 Wedderburn M, **Amon J,** Samiel S, Brathwaite A, Figueroa P. *Behavioral explanations for elevated prevalence of HIV in St. James Parish, Jamaica.* XII Int Conf AIDS. 1998; 12:216-7 (abstract no. 14171).

5 D'Angelo LA, **Amon J,** Lemos ME, Rebeiro MA, Gitchens W, Kotellos K. *Evaluating capacity building of implementing agencies in the AIDSCAP Brazil project*. XII Int Conf AIDS. 1998;12:945 (abstract no. 43503).

6 Saidel T, Mills S, **Amon J,** Rehle T. *Behavioral Surveillance Surveys (BSS) on specific target groups: a valuable complement to standardized general population surveys*. XII Int Conf AIDS. 1998;12:233 (abstract no.14256).

7 Essah KAS, Jackson D, Attafuah JD, **Amon J**, Yeboah KG. *Findings from the 2000 behavioral surveillance survey in Ghana*. XIV International AIDS Conference: Abstract no. C11062

8 Chatterji M, Murray N, Dougherty L, Alkenbrack S, Winfrey B, **Amon J**, Ventimiglia T, Mukaneza A. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* XV Int Conf on AIDS, 2004 (Abstract WePeD6602).

9 Murray NJ, Chatterji M, Dougherty L, Winfrey B, Buek K, **Amon J**, Mulenga Y, Jones A. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* XV Int Conf on AIDS, 2004 (Abstract TuOrD1218).

10 **Amon J**, Devasia R, Xia G, *et al. Molecular Epidemiologic Investigation of Hepatitis A Outbreaks, 2003*. 4th International Conference on Emerging Infectious Disease, Atlanta, GA, March 2004.

11 **Amon J**, Devasia R, Xia G, *et al. Multiple Hepatitis A Outbreaks Associated with Green Onions among Restaurant Patrons – Tennessee, Georgia, and North Carolina, 2003.* 53rd EIS Conference, Atlanta, GA, April 2004. (Winner, Mackel Award)

12 Chatterji M, Murray N, Dougherty L, Ventimiglia T, Mukaneza A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* International Union for the Scientific Study of Population XXV International Population Conference Tours, France, July, 2005.

13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**.. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* International Union for the Scientific Study of Population. International Population Conference France, July, 2005.

14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J.** *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.

16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.

17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J**. *Local and cultural beliefs about HIV transmission fuel childrenīs rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.

18 Cohen J, Epstein H, **Amon J**. *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.

19 Schleifer R, Skala P, Lezhentsev K, **Amon J**. *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.

20 **Amon, J**. *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.

21 Ngonyama L, Lohman D, Clayton M, **Amon J**. *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.

22 Lohman D, Ovchinnikova M, **Amon J**. *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.

23 **Amon J**. *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.

24 Lohman D, Ngonyama L, Clayton M, **Amon J**. *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.

25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province*. XVII International AIDS Conference: Abstract no. THPE1085. August 2008.

26 **Amon J**. Protecting the human rights of people at risk of and affected by TB. 3rd Stop TB Partners Forum, Rio March 2009

27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009

28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.

29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.

30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.

31 **Amon J**. *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.

32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

Biomedical Prevention and Treatment Interventions - The Critical Role of Social Science, Law and Human Rights. International AIDS Society Conference. Cape Town, South Africa. July 2009.

33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.

34 Pearshouse R, **Amon JJ**. *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.

35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J**. *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202

36 Jones L, Akugizibwe P, **Amon J**, et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033

37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J**. *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAF0101

38 McLemore M, Winter M, **Amon J**. *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942

39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J**. *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)

40 Pearshouse R, Cohen JE, **Amon J**. *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203

41 Lohman D, Palat G, Nair S, **Amon J**, Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.

42 Kippenberg J, Thomas L, Lohman D, **Amon J**. *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.

43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.

44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.

45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.

46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.

47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)

48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.

49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.

50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.

51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.

52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)

53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

Universities for Global Health. Washington, DC. March 2013.

54 **Amon J.** *Enhanced HIV testing in the context of human rights*. 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination*. International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.

57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)

58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ,** et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.

59 **Amon J.** Epidemic transition: How will we achieve it while ensuring equity and quality? 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

1 University of North Carolina School of Public Health (March 2006)

2 Duke University School of Public Policy (October 2006)

3 University of Chicago (October 2006)

4 University of Toronto Law School (November 2006)

5 Columbia University Law School (Dec 2006, 2007, 2009)

6 University of Denver School of International Affairs (March 2007)

7 Georgetown University Law School (April 2007)

8 Columbia University School of International and Public Affairs (Feb and Oct 2007)

9 University of Connecticut School of Law (April 2009)

10 New York University (January 2011, November 2014)

11 University of Zurich (September 2011)

12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)

13 Yale University Law School (March 2013)

14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)

15 UCLA Law School (January 2014)

16 Stanford University Law & Medical Schools (January 2014)

17 University of Melbourne, Nossal Institute for Global Health (July 2014)

18 Fordham Law School (October 2014)

19 Northwestern University (November 2014; Nov 2015)

20 Dornsife School of Public Health, Drexel University (February 2018)

21 University of California San Diego (March 2018)

AWARDS

Centers for Disease Control and Prevention, Epidemic Intelligence Service, Mackel Award (Apr 2004)
Department of Health and Human Services, Public Health Service, Unit Commendation (Oct 2004)
Department of Health and Human Services, Secretary's Award for Distinguished Service (Aug 2005)

AD HOC REVIEWER

Journals:

New England Journal of Medicine, Lancet, International Journal of Epidemiology, STI, Global Public Health, Addiction, Hepatology, Health and Human Rights, Bulletin of the World Health Organization, Journal of the International AIDS Society, PLoS One, PLoS Medicine, Journal of the American Public Health Association, Anthropological Quarterly, Drug and Alcohol Dependence, Conflict and Health, BMC Public Health, Harm Reduction Journal, Law & Social Inquiry, Social Science and Medicine, Health and Human Rights Journal, International Journal of Drug Policy.

Grants:

Open Society Foundations, Public Health Program

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MICHAEL GRAHAM; ALEXUS DIGGS; HEATHER CONNOLLY;	:	
Plaintiffs-Petitioners,	:	**Case No.**
v.	:	
ALLEGHENY COUNTY; ORLANDO HARPER, Warden of Allegheny County Jail	:	**ELECTRONICALLY FILED**
Defendants-Respondents.	:	**IMMEDIATE RELIEF SOUGHT**

DECLARATION OF ALEXUS DIGGS

ALEXUS DIGGS, one of the Plaintiffs herein, hereby declares pursuant to 28 U.S.C. 1746 that the following is true and correct:

1. I am a plaintiff in this lawsuit. I am a 24 year-old woman currently held on pod 4F at ACJ. I suffer from high blood pressure, which places me at a heightened risk for more severe symptoms and potential death from Covid-19.

2. I am being held at ACJ as a pretrial detainee charged with Aggravated Harassment By Prisoner. My bail on these charges is set at 10.00% of $1,000.

3. I am also being held pursuant to a probation detainer, as my new charges would constitute a violation of probation if I am found guilty of them.

4. I am currently double-celled.

5. I have never been tested for Covid-19.

6. Yesterday I began feeling scratchiness in my throat, and today I have been experiencing a runny nose and sneezing. I have no way of knowing if these symptoms are because I have a cold or Covid-19.

7. Prior to April 1st, I had not been provided any information, advice, or instruction from medical or other staff at ACJ pertaining to Covid-19. The first time I heard the term social distancing was during a phone call with counsel on or around March 28.

8. On the morning of Wednesday, April 1st, I saw a new posting on a column on the pod, which included information about changes to the local court system and other Covid-19-related information that was court-related and notified us about cleaning measures that are supposed to take place on the pod. I requested to the correctional officer on-duty, CO Thomas, "Let us know when you post things and explain them to us." CO Thomas replied, "You're not kids. You don't need anybody to read you anything."

9. Later that morning, Warden Harper entered the pod to speak about "social distancing". He threatened to lock down the entire pod if we did not stay six feet away from each other. He stated, "I'm going be watching on the cameras, and if you don't stay 6 feet apart, you're going be locked in, and only come out two at a time.'

10. I asked, "What do you expect us to do when trays come?", as we eat in a communal setting and there are a limited number of tables. Warden Harper replied, "You can figure it out. I'm not going into technicalities."

11. Heather Connolly, a fellow plaintiff, asked, "How can you not care that we've got two people in each cell?" Warden Harper repeated, "You guys can figure it out.

I'm not going into technicalities. […] Well, do you guys want me to shut you down? […] We can't do nothing about double-celling."

12. He then stated, "I'm only answering two questions." He left the room immediately after.

13. I spoke to Major Vanchieri about what ACJ were doing to prevent people from contracting Covid-19. Major Vanchieri said that Warden Harper only came and spoke about social distancing to "scare" us, and that they know that social distancing is impossible to do in the jail.

14. Last Monday staff came and confiscated the second roll of toilet paper, limiting everybody to one roll each, and took the extra rolls off the pod. I have run out toilet paper in recent days and have to rely on other incarcerated people to be willing to share. Staff will not provide toilet paper as needed.,

15. There are 48 cells on 4F and about 20 of them are empty. All of the rest except two are occupied by two people.

16. Nobody on 4F has gloves or masks at the time of this declaration. Neither staff nor incarcerated people have masks.

17. We have not been allowed cleaning supplies inside of our cells. No additional cleaning is taking place in the cells.

18. The showers are also not being cleaned any more than usual. They are supposed to be cleaned every night, though this does not always happen. This means that people are always using the shower after many others have without any cleaning.

19. While there was initially some increased cleaning with bleach, it has been inconsistently done. They stopped doing it for about a week until cleaning again last night.

20. Group meals and recreation continue without any alteration. Showers and phones are all shared without sanitation in between.

21. I fear for my health and my life if I remain at ACJ.

I, Bret Grote, certify that I reviewed this declaration with Alexus Diggs by reading it to her over the telephone on April 2, 2020 and that she certified that the declaration was true and correct to the best of her knowledge.

/s/ Bret Grote
Bret Grote
PA I.D. No. 317273
Legal Director
Abolitionist Law Center
Pittsburgh, PA
15221
412-654-9070
bretgrote@abolitionistlawcenter.org

Dated: April 5, 2020

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MICHAEL GRAHAM; ALEXUS DIGGS; HEATHER CONNOLLY;	:	
Plaintiffs-Petitioners,	:	**Case No.**
v.	:	
ALLEGHENY COUNTY; ORLANDO HARPER, Warden of Allegheny County Jail	:	**ELECTRONICALLY FILED**
Defendants-Respondents.	:	**IMMEDIATE RELIEF SOUGHT**

DECLARATION OF LARNELL JONES

LARNELL JONES, currently incarcerated at Allegheny County Jail, hereby declares pursuant to 28 U.S.C. 1746 that the following is true and correct:

1. I am a 45 year-old man currently held on pod 3A at the Allegheny County Jail.

2. I suffer from asthma and hypertension, both of which place me at a heightened risk for more severe symptoms and potential death from Covid-19.

3. I have been held at ACJ since July 2019, as a pretrial federal detainee charged with a non-violent offense involving possession of a firearm by a person formerly convicted of a felony.

4. I regularly experience shortness of breath as a result of my asthma.

5. I have and use an inhaler two times every day.

6. I am very concerned that my asthma exposure to Covid-19 could result in a medical crisis or even my death.

7. I am also concerned that my age and hypertension will also make it harder for me to survive Covid-19.

8. I am currently single-celled, but that could change at any time.

9. There are 56 cells on 3A. Almost all of them are double-celled, meaning two people are celled in each. There are just two one-person cells.

10. Some people were moved out recently, and I was told there are 87 people on the pod right now.

11. Since August we have had recreation/out of cell time and meal time divided by tier. That is still the case. There are two tiers, so that means each time there is recreation time there are about 40-50 people out at a time. Same with meals.

12. People are still exercising as normal, playing basketball, moving next to each other in crowded areas.

13. Meals are eaten at tables on the pod that are about 4 by 4 feet, with chairs pulled up to each table and four guys sitting around it.

14. No ACJ officials or staff or medical personal have come to talk to us or provide us any information, advice, or instruction pertaining to Covid-19.

15. All they have done is put up some flyers announcing some changes, some additional cleaning in the common areas, and advising people to wash their hands.

16. Whenever I use the phone I typically use it right after somebody else has, and I am packed in next to people on either side who are using other phones. After I use it, other people use it without the phone being sanitized.

17. There are 10 phones on the pod and they are almost always all in use the limited times we are allowed out of our cells.

18. They are now cleaning the phones when we are locked in, but we use them right after other people without any sanitizing in between.

19. Showers are supposed to be cleaned each night, but they are used throughout the day by many people without cleaning in between.

20. We have not been provided any cleaning materials for use in our cells.

21. Today, we were allowed to clean our cells for the first time in over a month.

22. Nobody on 3D has gloves or masks. Neither staff nor incarcerated people have masks.

23. Those exhibiting symptoms consistent with Covid-19 on 3A are not given regular if any medical attention, they are not quarantined, and they are not tested.

24. Just last week I vomited a couple of days in a row. Correctional Officers told me they would send me upstairs to medical, but they never did.

25. More than a week ago I was experiencing very bad chest pains. I was taken to medical where they did an EKG. Medical sought a second opinion about her EKG and ordered stronger medication for my inhaler. Medical staff did not follow up yet, and said they will see me in two weeks.

26. I fear for my health and my life if I remain in ACJ.

I, Bret Grote, certify that I reviewed this declaration with Larnell Jones by reading it to him over the telephone on April 3, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

/s/ Bret Grote
Bret Grote
PA I.D. No. 317273
Legal Director
Abolitionist Law Center
Pittsburgh, PA
15221
412-654-9070

bretgrote@abolitionistlawcenter.org

Dated: April 3, 2020

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MICHAEL GRAHAM; ALEXUS DIGGS; HEATHER CONNOLLY; **Plaintiffs-Petitioners,** **v.** **ALLEGHENY COUNTY; ORLANDO HARPER, Warden of Allegheny County Jail** **Defendants-Respondents.**	:	**Case No.** **ELECTRONICALLY FILED** **IMMEDIATE RELIEF SOUGHT**

DECLARATION OF MICHAEL GRAHAM

MICHAEL GRAHAM, one of the Plaintiffs herein, hereby declares pursuant to 28 U.S.C. 1746 that the following is true and correct:

1. I am a plaintiff in this lawsuit. I am a 38 year-old man currently held on pod 6F at ACJ.

2. I suffer from Hepatitis C and asthma, which place me at a heightened risk for more severe symptoms and potential death from Covid-19.

3. I am being held at ACJ as a pretrial detainee charged with Criminal Solicitation and related non-violent charges. My bail on these charges is set at $5,000.

4. I am also being held pursuant to a probation detainer, as my new charges would constitute a violation of probation if I am found guilty of them.

5. I currently have a cellmate.

6. I have never been tested for Covid-19.

7. I recently returned to 6F from 8E, where I had been for 15 days.

8. On 6F, neither I nor anyone else on the pod has been provided any information, advice, or instruction from medical or other staff at ACJ pertaining to Covid-19.

9. I have been in the jail since November 19, 2018.

10. Since that date, I have not had access to my inhaler and have been denied access to it multiple times. I have likewise been denied breathing treatments. I have been told that they don't have a record of my illness.

11. When not in jail I use my inhaler as needed, which is typically once to three times per day.

12. Over the past week, I have been experiencing symptoms such as a low dry cough, runny nose, upset stomach and I vomited once.

13. I have seen sick call on approximately 5-6 occasions since October 2019, requesting my inhaler each time. To date, they have not provided that to me.

14. On 6F, all of those incarcerated are still eating our meals communally at tables, with typically four people per table. Most individuals continue to utilize the same liquid dispensers for juice.

15. They began split recreation today, meaning they are letting us out in smaller groups, but there are still about 25 people out at a time in close proximity to each other. We sit four at a table, we are shoulder to shoulder and across from one another in the phone, we use the phones after each other without them being sanitized, and people are still playing handball and basketball.

16. We are provided with one (1) roll of toilet paper per week per cell. There is a limited supply of soap, deodorant, and other hygiene products. Right now I have been

without a bar of soap since Wednesday, April 1. My cellmate and I use the same soap in our sink, and we frequently drink out of the same cups.

17. I estimate that there are 60 cells on 6F. Around half are empty, and most of the rest are occupied by two people.

18. Today, for the first time, they came onto the tier to provide us with masks. They were given to us by Corrections Officers who handled them with their bare hands. Nobody gave us any instructions on how to properly put them or take them off so that they retain their effectiveness

19. While there was initially some increased cleaning with bleach, it has been inconsistently done. And they do not let us clean our cells, we do not have cleaning supplies.

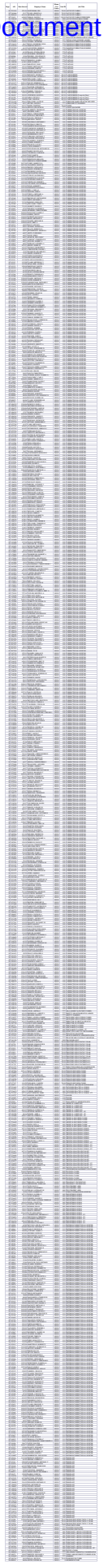
20. I fear for my health and my life if I remain at ACJ.

I, Bret Grote, certify that I reviewed this declaration with Michael Graham by reading it to her over the telephone on April 4, 2020 and that she certified that the declaration was true and correct to the best of her knowledge.

/s/ Bret Grote
Bret Grote
PA I.D. No. 317273
Legal Director
Abolitionist Law Center
Pittsburgh, PA
15221
412-654-9070
bretgrote@abolitionistlawcenter.org

Dated: April 4, 2020

	Allegheny County Employees	2/26/20	4/2/20
1	HEALTH SERVICES ADMINISTRATOR	0	1
2	DEPUTY HEALTH SERVICES ADMINISTRATOR	0	0
3	DIRECTOR OF NURSING	0	1
4	ASSISTANT DIRECTOR OF NURSING	2	2
5	DIRECTOR OF SUBSTANCE USE PROGRAMS	1	1
6	DIRECTOR OF MENTAL HEALTH PROGRAMS	0	0
7	CLINIC MANAGER	0	1
8	STAFF EDUCATOR	0	0
9	INFECTIOUS DISEASE COORDINATOR	0	0
10	DETOX NURSE COORDINATOR	0	0
11	ADMINISTRATIVE ASSISTANTS	2	2
12	SUPPLY CLERK	0	0
13	PAYROLL CLERK	0	0
14	ACCOUNTS PAYABLE	0	0
15	IT MANAGER	0	0
16	DISCHARGE PLANNERS	0	0
17	LICENSED PRACTICAL NURSE	6	6
18	LICENSED PRACTICAL NURSE - PT (16 hours/week)	2	2
19	MEDICAL ASSISTANT	4	4
20	MEDICAL ASSISTANT - PT (16 hours/week)	3	3
21	MEDICAL RECORDS CLERK	0	0
22	MEDICAL RECORDS CLERK - PT (16 hours/week)	0	0
23	MENTAL HEALTH REG NURSE	0	0
24	MENTAL HEALTH REG NURSE -PT (16 hours/week)	2	2
25	MENTAL HEALTH SPECIALIST	0	0
26	MENTAL HEALTH SPECIALIST - PT (16 hours/week)	2	2
27	PHARMACY/ MEDICATION TECHNICIAN	1	1
28	PHARMACY/ MEDICATION TECHNICIAN - PT (16 hours/week)	0	0
29	PSYCHIATRIC AIDE	1	2
30	REGISTERED NURSE	6	6
31	REGISTERED NURSE - PT (16 hours/week)	8	8
32	SUBSTANCE ABUSE COUNSELOR	1	0
33	SUBSTANCE ABUSE COUNSELOR - PT (16 hours/week)	2	2
34			
35	**Allegheny Health Network Employees**		
36	MEDICAL DIRECTOR	0	0
37	PHYSICIANS (Physical Health)	0	0
38	PHYSICIANS (Physical Health) - PT (16 hours/week)	0	0
39	MID LEVEL PRACTITIONERS (Physical Health)	0	0
40	MID LEVEL PRACTITIONERS (Physical Health) - PT (16 hours/week)	0	0
41	Physicians (Psychiatrists)	2	2
42	Physicians (Psychiatrists) - PT (8 hours/week)	0	0
43	MID LEVEL PRACTITIONERS (Mental Health)	0	0
44	MID LEVEL PRACTITIONERS (Mental Health) - PT	0	0
45	PSYCHOLOGIST - PT (20 hours/week)	0	0
46	X-RAY TECHNICIANS	0	0
	Total Vacancies:	**45**	**48**



COUNTY OF ALLEGHENY

RICH FITZGERALD
COUNTY EXECUTIVE

TO: Orlando L. Harper, Warden

FROM: Administrative Team: Chief Deputy Wardens, Deputy Warden, and Majors
Dr. Donald Stechschulte, Jr. Medical Director
Lauren Bach, Infectious Disease Coordinator
Robyn Smith, Healthcare Staffing Educator
Assistant Director's of Nursing

DATE: March 30, 2020

RE: Continuing of Operations Plan: COVID-19 (Updated)

SITUATION

COVID-19, Coronavirus disease 2019 is a novel (new) coronavirus that was first identified in Wuhan, China. The virus is believed to be spread from person-to person through respiratory droplets that are transferred through close contact. Typically, close contact is defined as within 6 feet. Disease transfer is believed to occur when an individual who is infected coughs or sneezes and a well person inhales the respiratory droplets. It is believed that indirect contact may occur when a surface or object has the virus and a well individual touches their mouth, nose, or eyes.

No vaccine or specific treatment for COVID-19 is currently available. Care is supportive for symptom reduction, elimination, or management. Reported illnesses have ranged from mild to severe, including illness resulting in death. Individuals who have travelled to places where the virus is occurring, or areas that are defined as having community spread, are at the most risk for contracting COVID-19. Patients with COVID-19 experience a respiratory illness (ranging from mild to severe) and symptoms include: fever, cough, and shortness of breath.

The threat of disease spread can be dramatically reduced by ensuring that employees/volunteers who are ill seek treatment and stay home, employ the use of appropriate hand hygiene, reduce or eliminate hand shaking contact, cover coughs/sneezes with the use of tissues or redirection of coughs and sneezes into elbows or sleeves, and routinely cleaning surface areas and frequently touched objects. As influenza is still active, it is important for general hygiene practices to be maintained and for individuals who feel sick to seek guidance and treatment from their healthcare professionals.

Much is to be learned about this new virus and updates will continue to be provided by the Center for Disease control and communicated to Federal, State, and Local Departments for dissemination through the appropriate designees. The Allegheny County Jail will continue to collaborate and coordinate with other County departments, to include the Health Department, to reduce the impact of disease spread.

ORLANDO L. HARPER, WARDEN
ALLEGHENY COUNTY JAIL
950 SECOND AVENUE • PITTSBURGH, PA 15219
PHONE (412) 350-2000 • (412) 350-2032
WWW.ALLEGHENYCOUNTY.US

Exhibit A

MISSION

The Allegheny County Jail will work to effectively reduce or mitigate the spread of illness throughout the facility. The Allegheny County Jail will ensure that all precautions are taken appropriately and that the health, safety, and security of all inmates, volunteers, and employees will remain the primary focus throughout planning and response periods.

This emergency preparedness plan will involve communication and collaboration with multiple county departments, to include, but not limited to: Allegheny County Health Department, Allegheny County Sheriff's Department, Allegheny County Emergency Medicine Services, Alternative Housing Departments, Allegheny Health Network, and Allegheny County Courts.

Additionally, the Allegheny County Jail will ensure that all individuals who are placed into our custody are afforded every available service to involve medical treatment if necessary, dietary needs when applicable, safe and secure processing from arraignment to release or incarceration, in accordance with all applicable laws, and ACJ policies and procedures.

EXECUTION

Throughout the facility, signage has been posted to increase awareness and educate on appropriate hand washing/hand hygiene as well as the signs/symptoms of COVID-19. Signs will notify that coughs and sneezes should be redirected into elbow or sleeve, hands shall be washed frequently with soap and water for at least 20 seconds, avoid touching face when possible and to clean surfaces frequently.

Appropriately diluted cleaning agents will be deployed to all areas of the facility (solution will be made with bleach). To clean surface areas, the area shall be saturated with the cleaning agent and will remain on the surface for 5 minutes to air dry. Areas, such as phones, should be saturated with the cleaning agent and wiped to allow for cleaning of all areas, should be permitted to air dry.

Employees will be reminded that if they are sick, they should seek medical treatment and follow the recommendations of their provider.

Personal Protective Equipment (PPE) will be made available to inmates and staff, as deemed appropriate. Authorized PPE may include surgical/procedural masks, goggles, N95 masks, gowns, and protective disposable gloves.

Increased availability of fluids (i.e. water) shall be made available to housing units where individuals are symptomatic.

Inmates will be screened upon entry to the facility and heightened attention will be given to those on the intake housing units.
Continuous contact and communication will occur with Jail Administration, Medical Director, and Allegheny County Health Department. All recommendations will be followed to prevent an outbreak within the facility.

As treatment, testing, or vaccinations become available, a coordinated plan will be developed and executed to reduce further spread of illness.

Changes in operations will be ongoing as more information becomes available and as the risk level of Allegheny County shall change (increase).

If any staff member, regardless of their department, is concerned about an inmate or other staff member having symptoms of respiratory illness, these should be immediately reportable to the ADON and/or Shift Commander. This will help ensure a more thorough surveillance of potential infection throughout the entire building. Our inmate population can be immediately seen by the healthcare department upon suspicion or presentation of symptoms. Reporting of another staff member to the Shift Commander and/or the ADON can help ensure potentially infectious staff members are sent home; appropriate cleaning procedures and contact tracing can also be conducted. These actions and heightened awareness and communication is vital to the health and safety of every individual who works or lives within the institutional walls.

EMPLOYEE SCREENING

Effective, Saturday 3/28/20, all employees (county and contracted) will be required to participate in screening in the Employee Entrance Vestibule.

Screening Procedure

Healthcare employees or a Contracted vendor will take the employee's temperature (temporal, tympanic, and oral thermometers available) while observing any visible symptoms and inquiring about the individual's recent travel, symptoms, and contact with others.

Questions asked:

1. Have you travelled outside of Pittsburgh within the past two (2) weeks?
2. Have you had any contact with anyone displaying symptoms of COVID-19?
3. Have you experienced any symptoms of COVID-19? (shortness of breath, cough, temperature, loss of smell, loss of taste)

If an employee has a temperature that is at or above 99.5 degrees Fahrenheit, they will be required to wait and have their temperature taken again in 3-5 minutes. The determination of 99.5 degrees is to account for 0.5 degree of variability with the thermometer as the Health Department currently recommends for precautions to be taken at 100.0 degrees Fahrenheit.

While waiting for the second temperature, the employee will be asked additional questions to include:

1. Have you noticed a temperature before we took yours today?
2. Have you been around anyone who has displayed symptoms of shortness of breath, coughing, loss of smell/taste, temperature within the last 14 days?
3. Have you had any known contact with anyone diagnosed with COVID-19?
4. Have you recently been around anybody known to be diagnosed with the flu or a different respiratory condition?

If the second temperature reading is at or above 99.5 degrees Fahrenheit, the employee will not be permitted to work for that day. The employee will be advised to contact UPMC Work Partners to open a leave of absence and site an Administrative Leave due to their positive screen.

The COVID-19 Employee Screening form will be completed, in its entirety, and submitted to supervisory staff. The supervisor will make adjustments to the schedule to reflect this employee's absence and will forward the form appropriately. This form will be submitted to Payroll to ensure that the documentation accounts for their date of missed work.

If the employee does not develop symptoms, they are permitted to return to work on their next scheduled day. If the employee does develop symptoms, they should make notification to HR/Administration and should be directed to reach out to their Healthcare Provider for testing. Testing can also be arranged through the Allegheny County Health Department.

NEW ARRESTS/ADMISSIONS TO ALLEGHENY COUNTY JAIL

Healthcare Screening: Intake

At time of medical clearance, vitals will be taken of every incoming new arrest/detainee. All individuals will be screened with the following questions:

1. Does patient have fever? Yes or No
2. Does patient report any symptoms of upper or lower respiratory infection (cough, chest pain, shortness of breath)? Yes or No
3. Does patient report recent travel to, or contact with a person who has traveled to, a known affected area within the last 14 days? Yes or No
4. Does patient report contact with known laboratory confirmed case of COVID-19? Yes or No

Individuals who have a fever (based on vital signs) and answer yes to 2 or more of the proceeding questions shall be given a mask and placed in a single cell. Areas of travel will be documented within the progress notes and immediate notification to the Healthcare Manager on Duty. These individuals may be tested to determine if they have influenza. These individuals will be recognized as "additional precautions" and will also be prioritized for receiving screening to determine if there are any underlying medical conditions that may place them at a higher risk. Upon completion of all screens/assessments, healthcare staff shall wipe down all surface areas that the individual contacted (to include signature pad).

Healthcare professionals shall probe for more information when someone provides an affirmative response to the travel questionnaire. Additional questions shall be asked to assist in the identification of risk:

1. Was recent travel foreign or domestic?
2. Was there travel by airplane, vehicle, or train?
3. Were they in close contact (defined as within 6 feet) of someone who was demonstrating respiratory symptoms?
4. Do they have a fever or atypical vital signs and how long have you had these symptoms?
5. Have they been around someone who was diagnosed with a respiratory infection, influenza, or any other known illness that is NOT COVID-19?
6. Have they been around someone diagnosed with COVID-19 and where were they tested/diagnosed?

The intake supervisor will be informed of the individual's identity and the need for additional precautions at this time. The intake supervisor shall make notification to the ID department and Pre-trial services to ensure that the staff will exercise additional precautions.

The "at-risk" individual shall be placed in a holding cell alone or with other symptomatic individuals if space does not allow for single cell housing.

The Healthcare On-Site Manager (Assistant Director of Nursing or Healthcare Director) shall be notified when there are individuals who could be presumptive cases or persons under investigation. The provider will complete an assessment of the individual and the individual will be isolated in a holding cell. If clinical symptoms indicate a necessity to pursue testing, the health department will be consulted to determine if testing should be completed by calling [redacted]. The provider will review and complete the Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form. The provider will obtain the specimen as indicated by the PA Department of Health Coronavirus 2019 (COVID-19) Specimen Collection and Shipping Guidance form while wearing all approved PPE. The specimen shall be placed in a biohazard specimen bag and will be placed on ice until it is picked up for laboratory testing.

Individuals shall be encouraged to consume fluids and rest. Individuals who have medical conditions that may increase their risk of dehydration (i.e. detoxification) shall be provided with frequent offerings of beverages.

Intake holding cells have had soap dispensers added to allow for frequent hand washing of new arrests.

Housing in Intake

Female Holding Cells:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]

**Special precautions shall be taken with females who are pregnant. These individuals shall be prioritized through all screening processes to reduce/limit exposure.*

Male Holding Cells:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]

In order to mitigate risk and disease spread, healthcare and correctional staff will work to promptly process all individuals (per procedures) to reduce the requirement of shared spaces by large volumes of individuals.

Frequent cleaning of the cells and all surface areas (to include dayroom chairs in processing) will occur, on each shift, in intake.

Healthcare Screening: Sick Call

Healthcare staff shall be educated on the signs/symptoms of COVID-19 to provide ongoing education to the patient population.

Providers (mid-levels and physicians) will increase their engagement on the intake housing units to work to mitigate any disease spread and determine if individuals are presenting increased symptoms on the intake housing units so additional measures can be implemented to reduce disease spread.

During, any non-emergent healthcare interaction, an augmented form will accompany the healthcare employee to assess for evidence of fever (e.g., sweating, clammy skin, chills), upper respiratory complaints (ruling out history of smoking, asthma, seasonal allergies, other conditions that cause respiratory conditions), loss of smell or taste, recent travel to an area impacted by COVID-19, and/or recent contact with someone who is known to have been diagnosed with COVID-19.

The Healthcare On-Site Manager (Assistant Director of Nursing or Healthcare Director) shall be notified when there are individuals who could be presumptive cases.

Medication Pass

Medication pass will continue to be conducted on the general population housing units in the designated area (pantry). Inmates will be released per the institution's break in/break out procedures for administration of medications.

During medication pass, all inmates will be instructed to bring their own cups to medication line to eliminate or reduce the risk of transfer of property.

If an individual is on isolation precautions, the nurse will administer medications at the cell in a prepared envelope of medications. Healthcare staff will utilize the appropriate PPE during the interaction.

Medication Delivery (Kane Pharmacy)

Medication deliveries will be provided [redacted] to ensure that there are timely releases of inmates from the facility. Medication delivery will be provided in labelled paper bags and must be transitioned from the Kane Delivery Drive to a Healthcare Staff member (Medication Room Technician or other authorized individual).

Medication returns, for destruction, will no longer be accepted. Medications will be destroyed, on-site, per policies and procedures of the institution. Controlled substances will be witnessed during destruction and all destruction will be documented accordingly.

Dental

Following recommendations from the American Dental Association and the Allegheny County Health Department, non-emergent dental services and procedures will be delayed. Essential dental services will

ORLANDO L. HARPER, WARDEN
ALLEGHENY COUNTY JAIL
950 SECOND AVENUE • PITTSBURGH, PA 15219
PHONE (412) 350-2000 • (412) 350-2032
WWW.ALLEGHENYCOUNTY.US

continue to be provided. The contracted dental provider will continue to follow all appropriate measures of infection control.

Clinic Services
In order to reduce movement and communal settings for inmates from varying housing settings, the clinic will be closed except for necessary populations (e.g. pregnant females and radiology). Healthcare staff will be deployed to housing units to perform non-emergency healthcare requests, provider visits, or assist in other locations of the facility that have critical staffing needs.

Reducing Movement
When possible, individuals will remain on their housing units to receive services. If individuals within Allegheny County were to be diagnosed with COVID-19, determinations would be made to reduce movement in the facility to emergent movement.

NON-ESSENTIAL SERVICES

With additional direction from community stakeholders, it has been determined that the most responsible decision to reduce the risk of community spread will be to temporarily suspend non-essential services in the facility and restrict the number of individuals entering/exiting the facility. Due to these recommendations, classes in the education department, Reentry, large gyms, and housing units shall be suspended.

Further action plans for respective departments of "non-essential" services are defined below.

Education Services/Inmate Programs
In collaboration with the Allegheny Intermediate Unit (A.I.U.) leadership, contingency plans have been developed. A.I.U. Juvenile and Adult Education programs have developed education packets for weekly distribution to inmates to encourage ongoing learning and continued operations.

Education material for both Juvenile and Adult Education Programs will be stored in a Central Location [redacted] will be designated for emergency only). Material will be in manila folders labeled with each individual inmate's name.

Distribution of educational materials will be done by the Inmate Programs Administrator, Correctional Officer, or designee. Distribution time will be determined based on the ACJ procedure of who would be permitted to enter the housing units.

Additional outreach is occurring with contracted service providers and volunteers (i.e. Batterer's Intervention Program, Creative Writing, Veteran's Pod, Father's Support Group, and AA/NA) to develop course material on paper. The inmate participate would have to turn completed work at a designated time to receive credit.

Petey Greene mentors are also currently suspended from providing services within the facility.

Religious Services
Volunteers will be suspended until professional visits resume. Communal practice of religious services will be temporarily suspended. In collaboration with the Chaplaincy department, a reduced schedule will be developed

to allow for staff to provide religious support while reducing or mitigating the risk of any potential for disease spread. Materials necessary for religious observation will be provided to allow for the continued opportunity for inmates to privately observe their religious practices.

Chaplaincy Programs [redacted] and will continue to facilitate the following services: answering inmate requests for devotionals and scriptures, providing weekly devotional resources to the housing units, visiting inmates upon referrals, providing notice and support during death notifications or notifications of serious illness of their loved ones, responding to emergent needs for spiritual counseling, supplying reading glasses, and supplying leisure material (i.e. crossword puzzles, word searches, books).

HOPE/Pre-Release Program
Volunteers (therapists, yoga instructors, Bible study leaders, etc.) will be suspended until professional visits resume. HOPE/Pre-Release permanent staff will also complete curriculum and resource development from remote/off-site locations to reduce introduction of disease on the housing unit.

Re-Entry Services
Instructors, mentors, therapists, tutors, etc. will be suspended until professional visits resume. Contracted service providers (Parenting, Relationships, Thinking for Change, etc.) will develop and provide 1-2 week packets for distribution to the participating population.

Visitation
Contact visits are suspended until further notice. Ongoing conversations will take place to establish next steps for contact visits that are currently under court order.

Beginning Monday, March 16, 2020 and for the following two weeks, all social visits (even non-contact) will be suspended until further notice.

Visiting (M) levels have had paper towel dispensers installed and will have appropriately diluted solution (bleach) available for ongoing cleaning to take place.

Attorney visits will continue, as indicated. Additional considerations will be made to determine the feasibility/sustainability of video conferencing for visits.

Commissary Services
Staff employed by the Commissary vendor (TKC Holdings Inc.) shall ensure that they are briefed in their organizations COVID-19 Emergency Action Plan and all updates to their plan will be communicated to the Administration of the Allegheny County Jail.

Continued delivery of services will be permitted at the discretion of the Jail Administration. To observe recommendations for reduced contact and social distancing, contracted commissary employees will not count items with the inmate. Instead, the items will be packaged and provided in a bag to the inmate who will sign for receiving their order. Inmates who are unwilling to accept their order in this manner will not receive their items and will be credited for their order.

COURTS/TRANSFERS/LEGAL SERVICES/RELEASES

Per order of President Judge Kimberly Clark, the Court of Common Pleas of Allegheny County, Fifth Judicial District, invoked an order consistent with the Supreme Court of Pennsylvania to outline emergency operations from March 17-April 14, 2020. The order outlines the operations of the courts throughout this time period and will be expressly supported and followed by the Allegheny County Jail.

Excluding emergent circumstances, all inmates will be screened prior to their transfer off-site with any transporting agency. A "COVID-19 Transfer/Release Screening Form" will be completed to include the Name, Inmate Number, Date of Birth, Date of Completion, Temperature reading 1, Temperature reading 2, Indication of Respiratory Symptoms, Indications for Precautions, and the name of the Healthcare professional that completes the screening. This form will be scanned into their Electronic Health Record and a copy will be provided to the transporting agency.

Receiving Transfers from Other Facilities (County, State, and Federal)
Any information relevant to the population shall be coordinated with all points of contact at each facility. When transferring individuals from our facility to others, relevant screening information and health transfer sheets shall be sent to coordinate care.

Additional precautions shall be taken when receiving individuals from facilities where diagnoses have occurred.

Court Movement
Court movement will continue to follow all appropriate procedures. When possible, video conferencing will be utilized to limit the movement of individuals. If an individual is currently on precautionary/quarantine status, Pretrial services and the Judge will be notified to make determinations regarding their case. Sheriff's shall report any potential signs of illness during transports.

Video Arraignment
Until further notice, video arraignment will continue to follow their previously determined schedule with cooperation from multiple jurisdictions. If there is stakeholder interest in expanding services to accommodate video conferencing, the hours of operation will be modified to support these initiatives.

The video complex currently has [redacted] different video conferencing stations with [redacted] chairs capable of serving inmates. The chairs will be moved to comply with social distancing recommendations by spacing chairs apart by several feet.

To support ongoing violation hearings, the hearing officer can video conference from the [redacted] and the Probation Officers can be contacted via phone.

Should transfers to the courthouse discontinue, continued operations of video arraignment will be determined based on the indicated demand of services.

Transfers to Alternative Housing Sites (Renewal, Inc. and The Program for Offenders)
Beginning 3/13/20, transfers to alternative housing sites will cease to assist in their management of the population and decrease the incidence of disease spread. Each Alternative Housing provider will activate their continuing of operations plans and will provide those plans to the Administration at the Allegheny County Jail.

Permanent Releases from the Facility
Allegheny County Criminal Justice Representatives (Office of the Public Defender, Pre-Trial Services, District Attorney's Office, etc.) shall continue to review the current incarcerated population to determine if any non-violent offenders are eligible for release.

Discharge and Release processes will continue to be sustained throughout this time period and will be reducing the hours of operation to sustain services between 8:30am-5:00pm Sunday-Saturday. Services will continue to include offering Narcan, providing resources/referrals, facilitating phone calls, and providing bus tickets. All inmates who are prescribed medications will leave with the appropriate amount of medications and scripts (when applicable). During the additional evening hours, the Intake Supervisory staff will be prepared to provide vouchers for public transportation use.

The Cashier's Office will also work with reduced hours. If individuals are released outside of hours, coordination will be made to ensure that they receive the money from their accounts in accordance with policy and procedure.

Transfers to the Hospital
Any urgent or emergent medical needs that exceed the level of care that can be provided on-site will be referred to an appropriate off-site treatment provider. Excluding emergent trips, a transfer screening will be completed to accompany the inmate. The receiving provider will also be notified, prior to receiving the inmate, of any risk factors or persons under investigation to appropriately prepare for the new admission.

In emergent transports, when 911 is called, the dispatcher must be informed if the patient has symptoms of COVID-19. This notification will allow the responders to ensure the utilization of the appropriate PPE for the transport and will also make additional notification to the receiving hospital.

In collaboration with our institutional medical partner, Allegheny Health Network (AHN) has requested that procedures be limited to emergent or planned medically urgent at all of their AHN sites. AHN has requested a cancellation or postponement of *elective and not medically urgent* procedures.

AHN has defined *elective and not medically urgent* to include: screening endoscopy, elective arthroplasty, neurologically-intact spine surgery, outpatient arthroscopy, delayed breast reconstruction, ostomy reversals, aesthetic surgery, reducible hernias, elective SVT ablations US guided thyroid biopsies, joint injections/arthrograms.

AHN has defined *planned medically urgent* to include: cancer surgery, interventional cardiac catheterization, fractures, acute infections, cholecystitis, appendicitis, CABGs, tendon/nerve injuries, tracheostomies, other procedures that will facilitate patient disposition.

AHN has defined *emergent* to include, but not limited to: open fractures, limb ischemia, intracranial hemorrhage, penetrating trauma, bowel perforation/ischemia, bleeding, neurologically-compromised spine surgery.

TREATMENT

Incarcerated individuals who can be managed on-site will be encouraged to rest and drink fluids. Individuals will remain locked in their cells and separated from the general population. Medicines will be provided, at the discretion of the healthcare providers, to address their symptoms (i.e. acetaminophen for fever reduction). Monitoring and treatment determinations will be made by the authorized healthcare providers.

If an individual is diagnosed with COVID-19, medication pass will be conducted at their cell door. Healthcare professionals and correctional staff should utilize precautions and wash hands after contact with individuals who are sick.

If the incarcerated individual's illness and symptoms are too severe, warranting a higher level of care, transfer will be coordinated with one of the local hospitals for admission. At time of transport, the inmate shall be provided with a surgical/procedure mask and transporting staff will be provided with N95 masks. All healthcare and correctional staff shall utilize disposable gloves.

DIETARY

Staff employed by the Dietary vendor (TKC Holdings Inc.) shall ensure that they are briefed in their organizations COVID-19 Emergency Action Plan and all updates to their plan will be communicated to the Administration of the Allegheny County Jail.
Dietary vendor will ensure that frequent cleaning occurs throughout the kitchen area and will avoid contact with food. All inmate workers will continue to utilize appropriate protective measures. Dietary vendor will ensure compliance to all indicated measures to promote food safety.

To reduce exposure from the inmate population to staff, Trinity Take Out (TTO) will be discontinued until further notice.

Inmates who are on precautionary or isolation status will be provided their food in a disposable container.

ENVIRONMENTAL CLEANING

Authorized cleaning agents will be deployed to Employee Lounge/ODR, Control Booth, Shift Commander's Office, Education Department, Chaplaincy Department, Discharge and Release Center, and other areas that employees frequently occupy. Employees shall be responsible for ensuring that they maintain cleaning within their designated areas.

ENVIRONMENTAL CLEANING: VISTING LOBBY/FAMILY ACTIVITY CENTER

The following considerations are applicable for the duration of time that visits are still operational (social, professional, legal). When visits are discontinued in full, cleaning will continue with less frequency.

The Visiting lobby will continue to be cleaned by the assigned inmate work crew (i.e. Street Gang inmates) who have been trained in cleaning procedures. The following areas will receive additional attention:

The restrooms utilized by Visitors will be cleaned prior to visits being started, during count times, or other times as designated. The sinks will be wiped down with an authorized cleaning agent, all toilets will be flushed, all trash containers will be emptied, toilet paper will be re-supplied, and papertowels will be made available. Any soap dispensers will be filled.

The Family Activity Center area will be cleaned daily.

The door handles going to the elevators will be cleaned after all visits.

ENVIRONMENTAL CLEANING: VISITING/MEZZANINE/HOUSING LEVELS

Sanitization efforts will be routine and consistently occuring on each shift.

Hallway workers will wipe down the door handles of the various outside Pod access doors hourly or as directed by the assigned Correctional Officer using the provided cleaning agent.

Officer stations located on the Levels will have those items and equipment that is physically utilized by the assigned Officers wiped down as necessary using provided cleaning agent. The spray bottle containing the provided cleaning agent will be secured in the level supply closet when not in use.

Additional cleaning supplies will be provided to level 5 due to the operational tempo because of the use of the video conference center, and the increased level of anticipated use.

The daily routine of filling the hand cleansing dispensers will continue, with periodic follow up to ensure that the dispenser is filled for use by Visitors.

The visiting levels have had additional paper towel dispensers installed and will be outfitted with access to authorized cleaning agents. The Officer shall monitor the status of supplies and notify supervisory staff of any needs. Visitors shall be encouraged to utilize cleaning supplies for the visiting phones.

The M levels will be cleaned daily by sweeping and mopping by an assigned inmate cleaning detail supervised by assigned Correctional Officers. The door handles to the visiting booths will be cleaned as necessary.

ENVIRONMENTAL CLEANING: HOUSING UNITS

Cleaning supplies will be routinely deployed to the housing units for cleaning of all shared areas and cells. Regular environmental cleaning is encouraged to reduce the risk of respiratory illness transmission, as several

of these pathogens can live on surfaces for extended periods of time. EPA-approved disinfectants should kill enveloped viruses and have coverage for emerging viral pathogens.

The Correctional Officers assigned duties on the housing unit, or other designated areas, will ensure that inmates assigned cleaning duties will be responsible for the general housing areas, common areas, dayroom space, pod furniture, and other areas as designated. The inmates will be supervised while utilizing the authorized cleaning agents/chemicals. Sweeping, mopping, cleaning, wiping, and collection of trash/garbage shall be designated by the Correctional officer.

Sinks
All sinks in the Housing Unit Pantry will be cleaned after every meal serving. Sinks will not contain standing water when not being used for cleaning items and sinks will not be left running. If necessary, a work order will be submitted to correct any plumbing issues. Particular attention shall be given to the faucet handles and other areas that are “high volume” in touch.

Showers
All shower stalls will be cleaned utilizing all designated cleaning agents after every general use. The Shower cleaning detail will be used during all lock ins and count times (once the count is cleared) when the showers are not in general use.

Housing Unit Floors
The pod floors will be swept and mopped after every meal and once the pod is locked in after recreation period. The pantry floor will be swept and mopped after every meal period. The sally port floor will also be swept and mopped routinely due to the nature of a high traffic area.

Housing Unit Furniture
All pod furniture, to include tables and chairs, will be cleaned at a minimum of once a shift and after every meal period. All table tops will be cleaned using disinfectant after every meal period, and the pod chairs will be wiped down with disinfectant being utilized on the arm area of the chair, ensure that the surface areas of tables are dry before use.

Law Library/Commissary Kiosk(s)
Kiosks, stools, and tables will be cleaned after every use with authorized cleaning supplies.

Inmate Phones
Due to the proximity of phones to an inmate’s mouth and the higher risk of disease spread, additional attention shall be given to the inmate phones for calls and non-contact visits.

Trash Receptacles
All trash receptacles will be emptied per policy or as necessary. For example, receptacles shall not be more than half full at all times. Trash receptacles will be covered, when applicable. Trash receptacles shall not include any biohazardous waste materials.

Biohazardous Waste
Biohazardous waste will be collected in the appropriately indicated waste bags and bins. These areas will be monitored by healthcare staff and will be emptied routinely. When emptied, the bags will be appropriately secured in the Biohazard room. If needed, the contracted company will be contacted to schedule more frequent pick ups for removal of waste.

Stairs and Second Tiers
The second level tiers will be swept and mopped every shift and the stairs will be cleaned by wiping giving special attention to the area immediately under the first 4 steps. The railings of the stairs and second level tiers will be disinfected during count times by the Pod workers.

Supply Closet
The supply closet will be cleaned at least once per shift, with all cleaning equipment being returned to the closet for accountability purposes in accordance with current policy when equipment is not in use. All paper towels or other cleaning impliments will be stored and issued from the supply closet by the Pod Officer as needed for cleaning purposes. All cleaning chemicals/agents will be accounted for and stored in the closet per policy.

Inmate Cells
All inmates will be held accountable for their assigned cell. Inmates will be required to conduct cell cleaning with special attention to the following areas:

Toilets
All toilets will be clean and flushed, i.e. there should be no toilet paper, feces, or other items in the toilet bowl.

Cell Sinks
Sinks will be clean and free of standing water. Pod Officers will submit a work order as soon as possible, after verifying, for sinks that are not operable.

Cell Floors
Cell floors will be swept and mopped per institutional cell cleaning policy. There will be no blankets used as rugs (exception will be a prayer rug). All items will be neatly stored under the bunk in the inmate's individual storage container (bin). Footwear will be placed neatly under the bunk. When the bed is not in use, the issued blankets will be folded and placed on the mattress.

Cell Walls
Cell walls will be clean and free of pictures and clothes lines.

Cell Table/Stool
Table surfaces will be clean and any items on the table will be placed in a neat and orderly fashion.

Trash
Any trash in the cell will be located by the cell door and will be taken by the inmate to one of the trash receptacles on the pod when able.

ENVIRONMENTAL CLEANING: GROUND LEVEL/INTAKE

Intake workers will be tasked with the continuous cleaning of all commonly touched areas in our Intake Department to include, but not limited to: phones, door handles, walls, and counter tops. When a cell is vacant, an inmate worker will clean the cell (wiping down walls, bunks, sinks, inside/outside of doors, and toilets). At not time should the same rag be utilized to clean all areas simultaneously. This work is also to include the continuous sweeping and mopping of floors. As an extra precaution, inmate workers will be provided with Kaivac machines on the weekends for thorough cleaning of cells when vacated.

In addition to the holding cells, Intake, Processing, Pre-Arraignment, Supply, Laundry, Tool Room, and Kitchen shall be frequently monitored and cleaned.

Supply
Correctional Officers assigned to supply/tool room will be responsible for disinfecting all utilized tools and frequently touched surface areas with the approved cleaning agent. The Officer(s) assigned will be responsible for the direct supervision of inmates who will also be engaging in cleaning (sweeping, mopping, disinfecting).

Kitchen

The contracted dietary provider, inmate workers, and Correctional Officers will continue to follow all hygiene guidelines in accordance with policies and procedures as well as the Health Department for cleanliness and food preparation. All individuals who have contact with food will continue to wear the appropriate gloves/barriers/hairnets when handling food products and will frequently sanitize and clean their areas.

Inmate workers who are displaying symptoms of respiratory illness shall not be permitted to work and shall be evaluated by the healthcare department.

After 2000 hours, the final daily cleaning of the kitchen will be completed by remaining inmate kitchen workers. All surface areas will be cleaned with the authorized cleaning agent and all sinks/receptacles will be free of standing water.

Additional cleaning supplies will be deployed to accomplish these objectives and will be managed/controlled by the correctional officers and Intake supervisors.

ENVIRONMENTAL CLEANING: ELEVATORS

Every hour central control will direct the elevators to ground level for cleaning. Kitchen/Ground floor officers will utilize inmate workers to clean the elevators with the authorized cleaning agents to include the following considerations: ensuring all cars are free of debris, sanitizing hand rails, sanitizing the elevator control panel, and ensuring that the floor is sprayed with the cleaning agent.

ENVIRONMENTAL CLEANING: EMPLOYEE ENTRANCE

Nightly, the 1M cleaning crew shall conduct a thorough cleaning of the employee entrance, to include the employee entrance elevator and stairwell. Due to this being a high volume/traffic area, the employee entrance Sergeant shall ensure thorough cleaning of this area to include the entrance desk, doors, railings, lockers, bins, and any other applicable surface area.

ENVIRONMENTAL CLEANING: RESTRAINTS

After the use of handcuffs, leg irons, waist chains, and/or restraint chairs, the tools will be thoroughly cleaned and sanitized with an authorized agent before they are utilized with another contact/inmate.

If therapeutic restraints are indicated, these must be sanitized before use with another contact/inmate.

Spit masks will be disposed after use.

INMATE PHONE CALLS

With support from Global Tel*Link (GTL), beginning Thursday, March 19 through April 14, 2020 every inmate who is eligible for phone calls (not currently on restrictions) will have access to 1 free minute phone call each day. No credit is given for unused phone calls. Each housing unit will have a sign posted to indicate the process for the phone calls

INMATE HYGIENE

All inmates will be required to meet personal hygiene needs daily. All inmates will be required to shower at a minimum of 3 times per week. Soap will be issued to all inmates by the assigned Correctional Officer for frequent hand washing in cells. Correctional Officers will notify their respective Unit Managers of any issues at is relates to potential hygiene issues with any inmates assigned to their housing unit.

INMATE RECREATION

To comply with recommendations to reduce groups larger than 10, considerations will be made for intake housing units to reduce the interaction between individuals who may require additional screening.

POPULATION MANAGEMENT

With a reduced population, considerations will be made for the most appropriate management of the population. If housing units are temporarily closed, these units may be designated as units to house "sick" individuals in the future to ensure mitigation of disease spread.

SUPPLIES

Every housing unit shall be appropriately supplied with bars of soap to increase hand washing and hand hygiene. Every housing unit will be provided with access to the authorized cleaning agent for environmental cleaning on all shifts as detailed in previous sections of this plan.

Ongoing assessments will be made to ensure that there is available PPE.

Each housing unit should report if the hand sanitizer station is emptied. High volume areas (i.e. outside of elevators, entrances) shall be routinely assessed to determine if hand sanitizer stations need refilled.

Rationing of necessary supplies will be evaluated on an ongoing basis to ensure that all inmates are provided with supplies related to basic hygiene needs.

NOTIFICATION TO HEALTH DEPARTMENT

If the Allegheny County Jail has a suspected case, the healthcare manager on duty will notify the Medical Director. The Medical Director will make notification to the Chief Deputy Warden of Healthcare Services. The PA Department of Health will be contacted (1-877-PA-HEALTH) and local contacts will be made for Department of Health employees via their notification protocols and procedures.

Additional notifications will be made through appropriate utilization of the chain of command.

SPECIMEN TESTING

The established COVID-19 Testing Work Flow shall be utilized. All recommendations for specimen testing, via the PA Department of Health (DOH) and Bureau of Laboratories (BOL) shall be followed for collection and shipping guidelines. Testing will only be conducted with the explicit permission and coordination with the Allegheny County Health Department.

Healthcare personnel collecting samples from potentially infectious patients should follow standard precautions and all pertinent biosafety guidelines.

When positive screens are received for patients, recommended contact studies will be completed to determine if there are any other individuals who should have precautionary and isolation measures completed to mitigate further disease spread.

Positive inmate screens will be reported to Tom Greishaw with the PA Department of Corrections, excluding any identifiers, to provide incidence rates for each County Correctional Institution.

EMPLOYEE ILLNESS/STAFFING LEVELS

Employees who are ill should seek treatment and follow the recommendations of their healthcare provider.

As a correctional agency, safe and secure operations will remain the primary focus. Because compromised staffing could be a threat to secure operations, staffing levels will be monitored continuously.

[redacted]

Staffing levels and assignments of staff will be assessed, each shift, daily. Staffing levels will determine operational tempo.

Administrative staff will brief all necessary individuals daily to include the status of operations. Shift Commanders and Healthcare Managers (Assistant Director's of Nursing) will review the following shifts schedules and prepare for any necessary changes.

Non-Essential Employees
The following departments will be evaluated to determine if there is an opportunity for fewer employees to report to the facility and conduct their work from home via remote access:

Casework
Alternative Housing
Reentry Services
HOPE/Chaplaincy
Diversion
Administrative Services
Education/Inmate Programs

Employee Quarantine
If, at the explicit direction of a qualified healthcare provider, an employee is under isolation or quarantine procedures because of potential exposure to COVID-19, the employee will send notification to Jail Administration. They will provide any relevant information necessary for follow up. The Allegheny County Health Department will be contacted by Jail Administrative staff to confirm and identify any additional steps (to include a possible review of recent work assignment and contact).

To support employees during this pandemic period, Allegheny County is encouraging employees who are sick to stay home instead of reporting to work. The county has issued a temporary 14-day quarantine/incubation paid leave policy and requires the following actions to be taken to ensure the employee is eligible without utilization of their earned benefit time.

Employees eligible for this leave of absence must qualify with one of the following criteria:

1. The employee has tested positive for COVID-19;
2. The employee has been directed by a health care provider to self-quarantine because s/he is awaiting test results; or

3. The employee has underlying health concerns that may be impacted by the virus, and is being advised by his/her health care provider to self-quarantine

Employees must follow their call off procedures and also contact UPMC WorkPartners to open a leave of absence under the county's temporary 14-day policy. Employees will be required to provide documentation to UPMC WorkPartners to certify their leave.

The temporary 14-day policy does not cover situations in which employees need to stay home to care for family members who are "at risk," have chosen to self- quarantine and were not directed by a medical provider, or for any other reason other than those listed above.

The supervisor that is receiving the call off notification will gather the following information:

1. Are you electing to quarantine because you…
    a. Tested positive for COVID-19
    b. Were medically directed to
    c. Have a pre-existing condition and were medically directed to
2. What is the first date of your quarantine?
3. Can you provide a telephone number for an administrative staff person can contact you for follow up?

<u>If the employee is quarantined for testing positive or awaiting test results, supervisory staff will need to confirm all work assignments for the previous 6 shifts.</u> Priority screening will happen with all individuals who may have been in contact with the employee during their work assignments.

Employees: Positive COVID-19 testing

Reporting

Pennsylvania Emergency Management Agency (PEMA) is requesting that all First-Responder Agencies make notification regarding any employees that test positive for COVID-19. Names, specific medical information, and details should not be included. All reports shall be sent to Michael Spurr, Homeland Security/Law Enforcement Coordinator, via email Michael.Spurr@AlleghenyCounty.US with Allegheny County Emergency Services.

Contact Studies

When an employee has been confirmed, the Allegheny County Health Department will assist in providing direction based on the date of symptom presentation, the date the employee last worked, the capacity in which the employee worked, and the date that the employee was screened/tested positive. When the objective data has been gathered, the Allegheny County Health Department will provide direction for the designated dates that should be reviewed, utilizing CCTV footage, to establish employees that should be placed under isolation or quarantine procedures from these contact study reviews.

Healthcare Staffing

It is imperative that healthcare operations continue to ensure the safe maintenance of the inmate population. In the event that staffing levels no longer permit for the continued operations of healthcare staff, the following plan of action will be implemented.

Reduction of Services
Substance Use Counselors will discontinue group services on Level 4 and 5E. Staff will be redeployed to areas such as: non-emergency healthcare requests, mental health screening in intake, mental health units, case coordination/collaboration with community service providers such as JRS or CTT for discharge planning into the community.

Clinic staff will be redeployed to other areas of need (such as intake, 5B, or float positions).

Mental Health Specialists will provide support on segregated housing units, mental health units, intake, and non-emergency healthcare requests.

Nurses will ensure that medication passes are completed. Specialized nurses (i.e. detoxification nurse coordinator and staffing educator) will be tasked to fulfill other nursing functions to support the ongoing operations of necessary functions within the facility.

Healthcare managers, when applicable, will fulfill any necessary line staff roles to redeploy nurses to areas within the facility that indicate the highest need.

***Further pandemic staffing plans will be explicitly developed for each shift. Until further notice, staffing complications shall be immediately reported to the Duty Officer and Healthcare Duty Officer respectively.**

COMMAND

Allegheny County Jail Command Center – Warden's Conference Room

Facility Commander – Warden Orlando Harper [redacted]

Operation managers – Chief Deputy Warden David Zetwo [redacted] and Chief Deputy Warden Laura Williams [redacted]

Prison Managers: - Deputy Warden Jason Beasom [redacted] Major Adam Smith [redacted] Major Matthew Kohler [redacted] and Major Jack Vanchieri [redacted]

Medical Director – Dr. Donald Stechschulte, Jr. [redacted]

Shift Commander -as determined by shift assignment, [redacted]

Allegheny County Health Department

Jennifer Fiddner [redacted], Dr. Kristen Mertz [redacted], Ronald Sugar [redacted] Tom Mangan [redacted]

Allegheny County Sheriff's Department (ACSD)

Sheriff Liaisons – Lt. Tom Carter, [redacted] (Allegheny County Command Post) and Sgt. Tom Ninehouser, [redacted] (MCB – Jail Liaison)

Allegheny County Emergency Medical Services

Chief Matthew Brown [redacted], Assistant Chief Mark Pinchalk [redacted], EMS Coordinator Keith Morse [redacted]

Poison Control Center

Director, Amanda Korenoski [redacted]

cc: County Manager William McKain
Deputy County Managers Stephen Pilarski and Barbara Parees

ALLEGHENY COUNTY BUREAU OF CORRECTIONS	**APPLICABILITY: All Authorized Personnel**	
	POLICY NUMBER: #317	**DATE: 10/22/15** **REVIEWED: 9/20/18**
	TITLE: HOUSEKEEPING AND HYGIENE **ACA Standards- 1A-04** **TITLE 37-95.226(5), 95.231(1,2,5), 94.248(2)**	
	AUTHORIZED BY: ORLANDO L. HARPER **SIGNATURE:** Orlando L. Harper	

POLICY

It is the policy of the Allegheny County Jail to establish a sanitation and housekeeping plan. All inmates are required to maintain proper hygiene standards set forth in this policy.

PURPOSE

To provide a daily housekeeping plan by assigning responsibilities to inmates to maintain the prison living areas and general spaces in a sanitary condition.

PREFACE

It must be emphasized that **HAND WASHING** is the single most important method of preventing the spread of infections. It is imperative that all personnel wash their hands as often as possible, employing friction to all surfaces for not less than fifteen seconds each time.

SECTIONS

This policy will be segregated into two sections. Section one will outline general jail measures and section two will delineate cleaning for medical and special areas.

PROCEDURES

SECTION 1: GENERAL GUIDELINES

By order of the Warden; Shift Commanders, Unit Managers and Pod Officers are entrusted to implement the following:

1. All parts of the jail used by prisoners shall be properly maintained and kept clean at all times. Jail personnel are to be continually vigilant for identifying

Exhibit B

maintenance issues and unsanitary conditions and ensuring these conditions are promptly addressed for the health and safety of all concerned.

2. Upon admission to the institution, inmates will be provided with two (2) sets of uniforms and clean underwear.
3. Regular laundering of uniforms, underwear, and bed linens shall be done according posted laundry schedules. (See Policy #85 Laundry Procedures)
4. Inmates are expected to keep their cells clean and orderly. Cleaning supplies will be made available during mandatory shower and cell cleaning days.
5. Showers are available seven (7) days a week. Inmates are encouraged to use them on a daily basis. At a minimum, inmates in general population will bathe three (3) times a week Monday, Wednesday and Friday during mandatory shower and cleaning time. Disciplinary Custody inmates shall shower at least three (3) times a week based on the posted shower schedule.
6. Inmates may purchase basic hygiene supplies such as soap, shampoo, toothbrush, toothpaste and deodorant from commissary. Pod officers will maintain a supply of soap for inmates considered indigent. Indigent inmates are eligible for monthly hygiene kits that will include soap, deodorant, toothpaste and toothbrush by writing the supply sergeant. (See Policy #310)
7. Female inmates will be provided articles for feminine hygiene products when needed.
8. All exposed flooring is to be stripped and fully cleaned and waxed once per month. This includes jail physical plant, inmate pods and the jail infirmary.
9. Carpeted areas are to be vacuumed once and shampooed as needed. This includes jail physical plant, inmate pods and the jail infirmary.
10. Inmate living areas (cells) are to have all surfaces cleaned (wiped or mopped) with an infection control, approved hospital grade disinfectant between each occupation. Visible soil must be removed during the disinfection process.
11. All waste shall be disposed of in proper containers. All garbage containers must be cleaned and disinfected at least once a week.
12. Toilet areas are to be flushed clean. Commodes shall be cleaned using a suitable disinfectant/cleansing agent with cleaning equipment used for no other areas. (Toilet cleaning brushes are to be used on toilets **only**).
13. Toilet talking between inmates is forbidden and must be enforced.
14. Sink and drinking fountain areas are to be cleaned with an appropriate disinfectant, removing all visible residues and using cleaning equipment used for no other purpose.

15. Areas where food is stored and consumed must be sanitized on a continuous basis.
16. All balls and recreation equipment should be cleaned with appropriate germicidal solution on a regular basis but no less than daily.
17. All cleaning equipment, mops, sponges, brushes and any items used shall be maintained and stored in a manner that will not support growth and spread of pathogenic organisms. All equipment shall be clean and dry between uses and discarded as appropriate.
18. Environmental rounds to assess compliance with policies and standards shall be conducted on a routine basis.
19. Inmate workers and inmates themselves have a responsibility to keep living areas clean. Jail personnel are to see that they do.

SANITATION AND HOUSEKEEPING PLAN

Inmates are required to maintain their immediate living area and adjacent general space in a sanitary condition. Correctional Officers are authorized to assign up to six (6) inmate workers on his/her pod. The Correctional Officer has the discretion to hire an inmate as a worker. All workers are expected to maintain good habits of grooming. Workers assigned to Medical, Mental Health, Classification and Disciplinary Housing Units will be hired through Classification. It is the duty of the Pod Officer to ensure inmate workers complete their assigned duties. The following is a list of duties for all Pod Workers to be completed daily:

1. **Pantry Worker**
    1. Serve All Meals
    2. Clean and Sanitize Pantry Counter after Meals
    3. Sweep and Mop Pantry Floor
    4. Empty Pantry Garbage
    5. Distribute Diabetic Bags
    6. Sweep and Mop Sally Port
2. **C/O Area Worker**
    1. Sweep and Mop Gym
    2. Sweep and Mop C/O Area
    3. Empty C/O Trash
    4. Sweep and Mop C/O Bathroom
    5. Clean and Disinfect Sink and Toilet
    6. Clean Mirror and Stainless Steel
    7. Sweep and Mop Interview Room

3. Dayroom Worker
   1. Wipe Tables After Meals
   2. Sweep and Mop Dining Area (Vacuum if Applicable)
   3. Clean all Pod Windows
   4. Clean Dayroom Chairs
   5. Clean and Sanitize Pod Phones
   6. Sweep the Stairs

4. Counter Worker
   1. Work Outside Pantry Area
   2. Serve all Drinks
   3. Empty all Garbage Cans
   4. Sweep and Mop Counter Area
   5. Sweep and Mop Gym

5. Lower Level Worker
   1. Clean and Sanitize Lower Level Showers
   2. Sweep and Mop Lower Level
   3. Set-Out Cleaning Supplies
   4. Clean and Organize Janitor Closet
   5. Stack Chairs after All Meals
   6. Clean All Vents on the Lower Level

6. Upper Level Worker
   1. Clean Empty Cells as Needed
   2. Sweep and Mop Upper Level
   3. Clean and Maintain Visiting Areas
   4. Clean Upper Level Showers
   5. Stack Chairs After All Meals
   6. Clean All Vents on the Upper Level

SECTION 2: MEDICAL AREAS

Medical areas shall include, but are not limited to, any area staffed by medical persons, clinic areas, inmate holding cells, nursing staff areas, and hallways in the general medical area.

The following cleaning tasks are to take place in the medical areas:

1. All linoleum floors need to be stripped, fully cleaned and waxed. Particular attention needs to be paid to corners and edges. The floor in storage room in the small hallway off the main clinic hall also needs particular attention.

2. All windows and sills need to be cleaned. All trim around doors, door surfaces and knobs need to be cleaned.
3. Tile floors in the bathrooms and other areas need to be scrubbed with a brush.
4. All toilets, sinks, etc. need to be thoroughly scrubbed.

Guidelines for Routine/Ongoing Cleaning of Medical Areas

1. General instruction: A germicidal detergent solution shall be used to clean surfaces following product label for use and dilution.

2. Wet mopping: All medical areas shall be wet mopped at least two times per 24-hour day. This shall occur on the following schedule, not to interfere with scheduled medical clinics:
   a) Before 0800 hour each morning.
   b) Between 1700 and 1900 hours each afternoon.
   c) Additional wet mop cleaning shall be done as indicated by special circumstances requiring clean up.
   d) Mops and mop heads should be laundered in hot water and dried with high heat no less than weekly.

3. Strip/wax: All medical area floors shall be stripped and re-waxed at least one time each month, during non-clinic hours.

4. Trash: Cleaning of areas shall include removal of trash. Biohazard trash shall be appropriately disposed of in biohazard boxes.

5. Carpets: Carpeted areas shall be vacuumed as needed, at a minimum of once a week. All carpets shall be periodically steam cleaned.

6. Medical Clinics: Medical staff shall be responsible for cleaning of medical clinic counters and countertops.

7. General cleaning: Cleaning shall include, but is not limited to:
   a) Scrubbing of sinks,
   b) Scrubbing of toilets,
   c) Filling toilet tissue holders,
   d) Filling paper towel receptacles,
   e) Filling of soap dispensers,
   f) Restroom counter tops,

g) Wet wiping windowsills (and any other dust prone surface)
h) Clean mirrors,
i) Medical clinic examination tables shall be cleaned with disinfectant at least every twenty-four (24) hours and more often if visible soil is present.

Equipment Maintenance

Cleaning equipment, mops sponges, brushes and any item used shall be maintained and stored in a manner that will not support growth and spread of pathogenic organisms. This means that equipment shall be clean and dry between uses and discarded as appropriate. Any equipment giving off a foul odor shall be discarded or sent to the laundry if appropriate. Equipment used for sink cleaning shall NOT be used for any other purpose. Equipment used for drinking fountain cleaning shall not be used for any other purpose.

Cleaning directions for specialized areas/situations

Holding Cells/Close Observation Cells

- All surfaces shall be cleaned (wiped or mopped) with an infection control approved hospital grade disinfectant (1) between each occupation. Visible soil must be removed during this process.
- All waste shall be disposed of in proper containers.
- Toilet/elimination areas are to be flushed clean. Commodes shall be cleaned using a suitable disinfectant/cleaning agent and cleaning equipment will be used for no other areas. (Toilet cleaning brushes to be used on toilets only).
- Sink and drinking fountain areas are to be cleaned with an appropriate disinfectant, removing all visible residues, and using cleaning equipment used for no other purpose.
- In the event that any of the above areas are occupied on a continuous basis for a period of 24 hours or more, the area shall be observed for unsanitary conditions and cleaned as appropriate to maintain the health and safety of inmates occupying the room.
- All cleaning equipment shall be maintained and stored in a manner that will not support growth and spread of pathogenic organisms. Equipment shall be replaced as appropriate. Mop heads should be discarded and replaced on a monthly basis, as needed.
- Environmental rounds to assess compliance with policies and standards shall be conducted on a routine basis.

Infirmary Housing Area

- Inmate/patients who are physically able shall maintain a clean and safe environment in their cell/room area.
- There shall be no uneaten foods (saved food items from meal trays) kept in any Infirmary cells.
- Trash should be removed from the room at the conclusion of each shift. Inmate/patient shall collect trash and have ready for removal.
- Inmate/patient who are too ill or physically unable to manage their cell/room environment shall be assisted in the above by officers or inmate workers as needed. Inmate/patients will cooperate in this measure.
- Medical cell/rooms shall be wet mopped twice daily. No accumulation of soil shall be permitted. Mops and mop heads should be laundered in hot water and dried with high heat no less than weekly.
- Environmental surfaces shall be wet wiped as needed to prevent any accumulation of dust and debris.
- Sinks and commodes shall be scrubbed daily.
- Showers shall be sprayed with a disinfectant after each use and thoroughly scrubbed/cleaned daily.
- The Level 5 Unit Manager shall be responsible for compliance.

<u>Guidelines for Cleaning an Area after an Inmate is Released</u>
Infirmary and Mental Health Units

1. All infirmary bedrooms and Mental Health Unit (MHU) bed areas shall be thoroughly cleaned as soon as possible following release of the inmate/patient from the room.

2. No room shall be placed back into service until the cleaning is completed.

3. All trash shall be removed from the room and disposed of in the appropriate container based on type of trash.

4. All environmental surfaces shall be cleaned with a bactericidal disinfectant (1).

    a) Commodes shall be flushed clear and scrubbed with equipment that shall be used for no other areas than commode cleaning.

b) Sinks shall be cleaned of all visible soil, and then scrubbed and wiped with a bactericidal disinfectant agent. The cleaning equipment used for this purpose shall not be used for any other purpose.
c) Furnishings such as bed frames, mattresses, bed side tables, stands and any other items in the room shall be scrubbed clean of any soil and then the entire surface shall be wiped with a bactericidal agent.
d) Walls shall be inspected for visible soil and cleaned of such using an approved disinfecting solution.
e) Floors shall be first cleaned of any debris followed by wet mopping with a clean mop using a bactericidal disinfectant.
f) No room shall be placed into service until the above cleaning is competed.
g) All cleaning equipment shall be maintained and stored in a manner that will not support growth and spread of pathogenic organisms. Mops should be dried between uses. Mops and mop heads should be laundered in hot water and dried with high heat no less than weekly.

5. Equipment shall be replaced as appropriate.

6. The pod offer is to ensure workers clean cells incompliance with this policy.

7. The Unit Manger will make routine inspections to ensure compliance with this policy.

ALLEGHENY COUNTY BUREAU OF CORRECTIONS	**APPLICABILITY: All Authorized Personnel**	
	POLICY NUMBER: #429	**EFFECTIVE: 3/1/15** **REVISED: 7/25/17**
	TITLE: Inmate Worker Guidelines **ACA 4-ALDF-5C-06, 5C-07, 5C-08, 5C-10, 5C-11, 5C-12, 7F-03** **Title 37: 95.235(1),95.235 (2), 95.235 (3), 95.235(4), 95.235(5)**	
	AUTHORIZED BY: ORLANDO L. HARPER **SIGNATURE:** Orlando L. Harper	

POLICY

It is the policy of the Allegheny County Bureau of Corrections to permit deserving, eligible inmates the ability to perform work related activities within the institution when available. Inmate working conditions will comply with all applicable federal, state, and local work safety laws and regulations. The work day will be in approximate to a work day in the community. Inmate performance will be regularly evaluated and recorded and inmates will receive written recognition of competencies they acquire. In addition, there will be no discrimination of an inmate based on his or her race, religion, national origin, gender or disability in regards to their access to being assigned a work detail.

It is against ACBOC policy for any correctional personnel to use their official position to secure privileges for themselves or others in association with the Bureau's inmate worker details.

APPLICABLE POPULATIONS

This policy applies to all inmates seeking a work assignment and to correctional personnel responsible for determining an inmate's eligibility to work.

- Prisoners awaiting trial and not sentenced to the jail shall not be required to work, except to keep their immediate areas in their assigned living quarters clean. However, a volunteer work program for non-sentenced inmates should be developed. Non-sentenced and pre-trial prisoners can voluntarily request consideration for an inmate work assignment by following the normal channels for such a request.

- Prisoners sentenced to the jail shall be assigned work when it is available.

PROCEDURAL GUIDELINES

The Classification Supervisor oversees the components for this policy. Any deviations from this policy must be authorized by the Warden or his/her designee.

1. Classification will maintain a continuous roster of prospective inmate workers.
2. Classification will acknowledge only those prospective inmates that utilize the Work Request Application submitted to the Classification Supervisor. Inmates are able to volunteer for work assignments.
3. Classification is responsible for maintaining worker levels on pods 1-A and 4-C. Maximum capacity of 110 inmates should be maintained on 1-A and 4-C at all times, to the extent possible.
4. Both sentenced and, with some exceptions, non-sentenced inmates are eligible for work assignments and can express their interest by submitting an application to the Classification Supervisor. Sentenced inmates are not required to work. The criterion for each work detail is described in the "Work Assignment Details and Qualifications" section of the policy.
5. The Classification Supervisor is responsible for the hiring and replacement of Warden's Level Workers for the administrative area.
6. The Classification Supervisor is the final authority in determining an inmate's work eligibility.
7. Inmates assigned a work detail shall be supervised by a person designated by the Warden or his/her designee. All workers are subject to searches as prescribed by procedure.
8. Inmates will be provided with appropriate clothing, supplies and tools for any work detail to which they are assigned. Inmates will receive supervision and direction on the proper use of any equipment or tools to be used by the inmate during any work assignment.
9. The following are the workers housing locations:
   i. Kitchen workers must be housed on 1A
   ii. Laundry workers and Street Gang must be housed on 4C

   All other workers may remain on their assigned housing pod and are not required to be housed on housing units 1A or 4C.

WORK ASSIGNMENT DETAILS AND QUALIFICATIONS

The following are the available work details and criteria/qualifications for inmate work assignments. Please note that inmate workers are approved by the Classification Supervisor:

A. Kitchen and Lounge Workers (applies to males and females)

- Must be a County inmate with a classification level of minimum or medium security (no State, Federal, or maximum security level inmates)
- If formerly on DHU status, must be off of that status for thirty (30) days
- Must be misconduct-free for at least thirty (30) days before being eligible for work
- Escape charges/convictions will be reviewed on a case-by-case basis
- Medical clearance is required
- Hiring Process:
    - i. The vendor is responsible for monitoring inmate worker levels utilizing the following scale:
        - 7 X 3 SHIFT: Kitchen Workers – 40 / Employee Lounge – 8
        - 3 x 11 SHIFT: Kitchen Workers – 40 / Employee Lounge – 6
    - ii. In the event inmate worker levels are deficient, the vendor is to contact the Shift Commander to rectify the deficiency.
    - iii. The vendor may relieve any inmate worker from their assigned job and direct the inmate to return to his/her housing unit. The vendor must notify correctional personnel and send an incident report to the classification supervisor (either by placing in his or her mailbox or emailing the report). Inmate workers may only be terminated by correctional personnel.
    - iv. The vendor must ensure all inmate workers for the designated areas defined in this directive are medically cleared for duty.

B. Warden Worker (females only)

- Must be housed on 4E
- Must be a County inmate with a classification level of minimum or medium security (no State, Federal, or maximum security level inmates)
- If formerly on DHU status, must be off of that status for thirty (30) days
- Must be sentenced with no open bonds

- Must be misconduct-free for at least thirty (30) days before being eligible for work
- Escape charges/convictions will be reviewed on a case-by-case basis
- Medical clearance is required

C. Street Gang

- Must be hired from pod 4C
- Must be a County inmate with a classification level of minimum or medium security.
- No current open charges
- Family division bonds must be $2,000.00 or less
- No founded misconducts on current jail commitment
- No escape charges or convictions; includes alternative housing "walk-aways"
- Medical clearance is required
- In addition to normal work duties, inmates assigned to the Street Gang may participate in community service work when available.

D. Laundry

- Must be hired from pod 4C
- Must be a County inmate with a classification level of minimum or medium security (no State, Federal, or maximum security level inmates)
- If formerly on DHU status, must be off of that status for thirty (30) days
- Must be misconduct-free for at least thirty (30) days before being eligible for work
- Medical clearance is required

E. Intake Workers

- Must be a County inmate with a classification level of minimum or medium security (no State, Federal, or maximum security level inmates)
- If formerly on DHU status, must be off of that status for thirty (30) days
- Must be misconduct-free for at least thirty (30) days before being eligible for work
- Medical clearance is required

F. DHU, Classroom, IM, 5B and Clinic

- Must be a County inmate with a classification level of minimum or medium security (no State, Federal, or maximum security level inmates)

- No criminal bonds, family division bonds of $1,000.00 or less
- Escape charges/convictions will be reviewed on a case-by-case basis
- Must be misconduct-free for at least thirty (30) days before being eligible for work

G. Hallway Workers

- Selected by Unit Managers and it is the responsibility of each Unit Manager to notify Classification as to the Names and DOC numbers of hallway workers on their respective unit. Likewise, Unit Managers must notify Classification when an inmate worker is fired, quits, transfers to another unit or becomes hospitalized.

H. Pod Workers

- Selected by Correctional Officers assigned to the Pod
- Must be a County inmate

Work Eligibility for Newly State Sentenced Inmates

Inmates that have been working three (3) months or more and receive a state sentence of 3 years or less may remain on their work assignment, except Street Gang, until they are released to a state facility.

Disciplinary Sanctions for Inmate Workers

Inmate workers that receive a total of three (3) informal sanctions or one (1) misconduct during their work assignment or while on their assigned pod will be suspended from work until the outcome of their misconduct hearing. At that time, the Classification Supervisor and or Segregation Supervisor will review the validity of the infraction to determine eligibility to resume work assignment and/or whether their behavior warrants transfer to another housing unit.

COMPENSATION

Inmates participating in work programs (other than personal housekeeping and housing are a cleaning) will be compensated in the following manner:

- Meals: Inmate workers will be compensated for their work by receiving a second meal tray at meal times.
- Visits: Eligible workers, inmates who have worked in the above named jobs for at least thirty days and have been proficient in their job duties, and inmates who

are have successfully completed an approved program may be considered for monthly contact visits. It is the responsibility of the Deputy Warden of Operations to consider such privileges. Approved inmates will receive a copy of their approved contact visitor request. Any inmate who is denied a contact visit will be notified in writing of the reason. Contact visits are a privilege and will be treated as such. Any misuse or abuse of this privilege by any inmate may result in the privilege being revoked. The administration has the right to suspend this privilege at any time due to emergency or security situation.

INMATE WORKER STAFFING LEVELS

Jail Administration is the final authority in determining the level of inmate labor within the institution.

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF PENNSYLVANIA

MICHAEL GRAHAM; ALEXUS DIGGS; HEATHER CONNOLLY;	:	
Plaintiffs-Petitioners,	:	**Case No.**
v.	:	
ALLEGHENY COUNTY; ORLANDO HARPER, Warden of Allegheny County Jail	:	**ELECTRONICALLY FILED**
Defendants-Respondents.	:	**IMMEDIATE RELIEF SOUGHT**

DECLARATION OF TERRY SUGGS

TERRY SUGGS, currently incarcerated at Allegheny County Jail, hereby declares pursuant to 28 U.S.C. 1746 that the following is true and correct:

1. I am a 35-year-old man currently held on pod 3D at the Allegheny County Jail.

2. I suffer from asthma, hypertension, and diabetes, all of which place me at a heightened risk for more severe symptoms and potential death from Covid-19.

3. I have been held at ACJ since February 26, 2019, as a pretrial federal detainee charged with non-violent offenses involving conspiracy to distribute and possession with intent to deliver.

4. I regularly experience shortness of breath as a result of my asthma.

5. I have requested an inhaler, and have been told by the jail that it was ordered, but it has taken more than a month and I am still without one.

6. I am very concerned that my breathing problems and exposure to Covid-19 could result in a medical crisis or even my death.

7. I am also concerned that my diabetes and hypertension will make it harder for me to survive Covid-19.

8. I am currently double-celled. My cellmate was recently brought to ACJ. He is 57 years-old. He came from the community and spent only four days in intake, meaning he was not quarantined.

9. It is impossible to be six-feet away from my cellmate, and we are in the cell about 21 hours each day.

10. There are 56 cells on 3D. Almost all of them are double-celled, meaning two people are celled in each. There are just two one-person cells.

11. For the last 8 months or so we have had recreation/out of cell time and meal time divided by tier. That is still the case. There are two tiers, so that means each time there is recreation there are about 50 people out at a time. Same with meals.

12. People are still exercising as normal, playing basketball, moving next to each in crowded areas.

13. Meals are eaten at tables on the pod that are about 4 by 4 feet, with chairs pulled up to each table and four guys sitting around it.

14. No ACJ officials or staff or medical personal have come to talk to us or provide us any information, advice, or instruction pertaining to Covid-19.

15. All they have done is put up some flyers announcing some changes, some additional cleaning in the common areas, and advising people to wash their hands.

16. Whenever I use the phone I typically use it right after somebody else has, and I am packed in next to people on either side who are using other phones. After I use it, other people use it without the phone being sanitized.

17. Showers are supposed to be cleaned each night, but they are used throughout the day by many people without cleaning in between.

18. We have not been provided any cleaning materials for use in our cells. Cells are cleaned once per week, every Friday, and that has been the routine the entire time I have been at ACJ.

19. Nobody on 3D has gloves or masks. Neither staff nor incarcerated people have masks.

20. We are given one bar of soap and one roll of toilet paper per person per week. They used to give two of each until about two weeks ago when they cut back due to alleged shortages.

21. At one point, this led to a fight over limited toilet paper after somebody ran out.

22. People have run out of toilet paper in the middle of the week and have taken to using request forms to wipe themselves.

23. Those exhibiting symptoms consistent with Covid-19 on 3D are not given regular if any medical attention, they are not quarantined, and they are not tested.

24. Just last week I felt I had a fever and the medical staff did not see me for five days after I put in a request slip. When they saw me they told me that the fever was because of my blood pressure. There was no follow up, my temperature was not taken again, I was not given a mask, not taken to the infirmary, and nobody sought to assess who

I had been in close proximity to in order to monitor them for any potential symptoms of Covid-19.

25. I fear for my health and my life if I remain in ACJ.

I, Bret Grote, certify that I reviewed this declaration with Terry Suggs by reading it to him over the telephone on April 3, 2020 and that he certified that the declaration was true and correct to the best of his knowledge.

/s/ Bret Grote
Bret Grote
PA I.D. No. 317273
Legal Director
Abolitionist Law Center
Pittsburgh, PA
15221
412-654-9070
bretgrote@abolitionistlawcenter.org

Dated: April 3, 2020