

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

JAMAAL CAMERON; RICHARD
BRIGGS; RAJ LEE; MICHAEL
CAMERON; MATTHEW
SAUNDERS, individually and on
behalf of all others similarly situated,

Plaintiffs,

v.

MICHAEL BOUCHARD, in his
official capacity as Sheriff of Oakland
County; CURTIS D. CHILDS, in his
official capacity as Commander of
Corrective Services; OAKLAND
COUNTY, MICHIGAN,

Defendants.

Case No.

**Petition for Writ of Habeas Corpus
and Complaint for Injunctive and
Declaratory Relief**

Class Action

IMMEDIATE RELIEF SOUGHT

CLASS ACTION COMPLAINT

1. The rate at which the novel coronavirus and its resulting disease, COVID-19, is ravaging the globe is unprecedented in modern society. The situation is especially grave in the state of Michigan, which currently ranks third in the country

for coronavirus-related deaths.¹ Hospitals in Southeast Michigan are already suffering and struggling to keep up with the rush of COVID-19 related patients.² The state's chief medical officer, Dr. Joneigh Khaldun, declared during a press conference on April 6, 2020 that state hospitals are overwhelmed because there are no signs that the rate of infection is slowing down.³

2. A mass outbreak of COVID-19 inside Michigan's jails and prisons is a major threat to the state's already fragile healthcare system. An outbreak in the Oakland County Jail ("Jail") will undoubtedly cause death and devastation to countless lives, including the people jailed, the people who work in the jail, and their families. Its impact will be felt across the state as valuable medical resources—already in short supply—are completely depleted. Medical experts have stressed that urgent action in the jails is an essential public health priority given that any

¹ Bobby Allyn, *After Surge In Cases, Michigan Now 3rd In Country For Coronavirus Deaths*, NPR (Mar. 31, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/03/31/824738996/after-surge-in-cases-michigan-now-3rd-in-country-for-coronavirus-deaths>.

² See, e.g., Kristen Jordan Shamus and Darcie Moran, *Nurses Protest Conditions at Detroit's Sinai-Grace, Said They Were Told to Leave*, Detroit Free Press (Apr. 6, 2020), https://www.freep.com/story/news/health/2020/04/06/detroit-dmc-sinai-grace-nurses/2953385001/?utm_source=oembed&utm_medium=onsite&utm_campaign=storylines&utm_content=news&utm_term=4566614002.

³ Courtney Vinopal, *WATCH: Michigan Gov. Gretchen Whitmer gives coronavirus update*, PBS (Apr. 6, 2020), <https://www.pbs.org/newshour/health/watch-live-michigan-gov-gretchen-whitmer-gives-coronavirus-update>.

outbreak will place incredible strain on regional hospitals and health centers. These institutions would bear the brunt of having to treat all infected people and would have fewer resources available to treat anyone who required medical attention, which will be disastrous when medical needs overwhelm the institutions' resources.⁴ Dr. Marc Stern, an expert in public health in jails and prisons, has emphasized the need to “reduce the number of persons incarcerated” in order to accomplish “critical public health aims” of protecting both incarcerated people and the public at large.⁵

3. Understanding the dire need for immediate action, medical and public health experts have urged sweeping precautionary measures in everyday life to slow the spread of this virus. Yet the very steps they deem necessary—such as regular handwashing, sanitizing one's environment, access to testing, prompt medical attention, and wearing protective gear—have been made impossible for the people confined in the Jail by the very officials responsible for their well-being.

4. Social distancing, the practice of maintaining at least six feet between you and others, is the single most important precaution anyone can take to prevent

⁴ Ex. 1, Decl. of Dr. Marc Stern ¶ 11; *see also* Ex. 2, Expert Decl. of Dr. Jaimie Meyer ¶¶ 16, 22, , *Velesaca v. Wolf*, Case No. 1:20-cv-01803-AKH, ECF Doc. 42 (S.D.N.Y. Mar. 16, 2020); Ex. 3, Expert Decl. of Elizabeth Y. Chiao ¶ 28, *Russell, et al. v. Harris County, Texas*, No. 4:19-cv-00226, ECF Doc. 32-2 (S.D. Tex. Mar. 27, 2020).

⁵ Stern Decl. ¶¶ 10-11.

the spread of Covid-19.⁶ Governors, mayors, and local city and county officials have all urged the public to practice social distancing.⁷ Gatherings where it is

⁶ *Coronavirus 2019*, Centers for Disease Control, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html>; Ryan Miller, *Coronavirus: What is social distancing? When should I quarantine versus isolate?*, USA Today (Mar. 12, 2020), <https://www.usatoday.com/story/news/health/2020/03/11/coronavirus-pandemic-quarantine-social-distancing-covid-19-defined/5020755002/> (“The CDC defines social distancing as ‘remaining out of congregate settings, avoiding mass gatherings and maintaining distance (approximately 6 feet) from others when possible.’”); Bruce Lee, *What Is Social Distancing? Here Are 10 Ways To Keep The Coronavirus Away*, Forbes (Mar. 14, 2020), <https://www.forbes.com/sites/brucelee/2020/03/14/with-covid-19-coronavirus-here-are-10-ways-to-social-distance-yourself/#1f51f86f606c>; *On Apr 5, 9 pm, light candles, diya for 9 min to dispel darkness of Coronavirus: PM Modi to nation*, MSN (Apr. 4, 2020) <https://www.msn.com/en-in/news/other/on-apr-5-9-pm-light-candles-diya-for-9-min-to-dispel-darkness-of-coronavirus-pm-modi-to-nation/ar-BB126Jzj>; Al Dothan, *Coffee County has first case of COVID-19*, WTVY (Apr. 2, 2020), <https://www.wtv.com/content/news/Coffee-County-has-first-case-of-COVID-19-569327441.html>; Taj Simmons, *As Roanoke County reports second case of COVID-19, 'It's upended every aspect of our normal lives'*, WSLs (Mar. 27, 2020), <https://www.wsls.com/news/local/2020/03/28/as-roanoke-county-reports-second-case-of-covid-19-its-upended-every-aspect-of-our-normal-lives/>; Suzannah Lyons, Olivia Willis, *Is coronavirus airborne, and how does it spread?*, ABC (Mar. 29, 2020) <https://www.abc.net.au/news/health/2020-03-28/is-coronavirus-airborne-covid19-australia/12090974>

⁷ *Michigan closes bars, stops restaurant dine-in, further limits gatherings*, WOODTV (Mar. 16, 2020), <https://www.woodtv.com/health/coronavirus/whitmer-orders-bars-restaurants-to-close-due-to-virus-concerns/>; Doug Mainwaring, *Governor urges 'social distancing' even among families at home*, LifeSite (Apr. 3, 2020), <https://www.lifesitenews.com/news/governor-urges-social-distancing-even-among-families-at-home>; Christian Berthelsen, Elise Young, *N.J., N.Y. Urge Residents to Stay Put With Peak Approaching*, Bloomberg (Apr. 9, 2020), <https://www.bloomberg.com/news/articles/2020-04-09/murphy-says-social-distancing-is-slowing-virus-spread-in-n-j>; Laura Ziegler, *Act Like You Have The Virus, Kansas City Officials Urge As They Step Up Social Distance Enforcement*, KCUR (Mar. 30, 2020), <https://www.kcur.org/post/act-you-have-virus-kansas-city->

impossible to maintain social distancing have been cancelled across the country and world.⁸ The police in several states are arresting or ticketing people who fail to maintain six feet of separation between themselves and others.⁹ But social distancing is impossible in the Jail as it is currently operated and at its current population levels.

officials-urge-they-step-social-distance-enforcement#stream/0; Kendall Downing, *City, county officials urge social distancing over Easter holiday weekend; City braces for COVID-19 budget impact*, WMC5 (Apr. 8, 2020), <https://www.wmcactionnews5.com/2020/04/08/city-county-officials-urge-social-distancing-over-easter-holiday-weekend-city-braces-covid-budget-impact/>; *Many People Will Get COVID-19' Says Mayor Garcetti As He Urges LA To Practice Social Distancing, Self-Quarantine*, CBSN Los Angeles (Mar. 14, 2020), <https://losangeles.cbslocal.com/2020/03/14/many-people-will-get-covid-19-says-mayor-garcetti-as-he-urges-la-to-practice-social-distancing-self-quarantine/>.

⁸ *A List of What's Been Canceled Because of the Coronavirus*, N.Y. Times (Apr. 1, 2020), <https://www.nytimes.com/article/cancelled-events-coronavirus.html>.

⁹ Hannah Fry, *Manhattan Beach issues 129 citations for coronavirus social-distancing*, Los Angeles Times (Apr. 7, 2020), <https://www.latimes.com/california/story/2020-04-07/manhattan-beach-citations-coronavirus-social-distancing-violations>; *Detroit police: Property owners will get social distancing violation ticket if crowd gathers*, Fox 2 (Apr. 6, 2020), <https://www.fox2detroit.com/news/detroit-police-property-owners-will-get-social-distancing-violation-ticket-if-crowd-gathers>; Katie Canales, *Police in California have started ticketing people having picnics and congregating in beach areas as law enforcement cracks down on violators of the statewide stay-at-home order*, Business Insider (Apr. 6, 2020), <https://www.businessinsider.com/california-giving-people-tickets-stay-at-home-coronavirus-2020-4>; Amanda Jackson, *Police are arresting and fining people for violating social distancing orders*, CNN (Apr. 1, 2020), <https://www.cnn.com/2020/03/31/us/violating-coronavirus-orders-trnd/index.html>. Alice Speria, *NYPD'S AGGRESSIVE POLICING RISKS SPREADING THE CORONAVIRUS*, The Intercept (Apr. 3, 2020), <https://theintercept.com/2020/04/03/nypd-social-distancing-arrests-coronavirus/>.

5. Given reports of at least 23 confirmed cases of COVID-19,¹⁰ an outbreak in the Jail is imminent and will cause death and devastation to countless lives, including the people jailed, the people who work in the jail, their families, and the public at large. The County and the people responsible for operating the Jail, however, have failed to adequately respond to the obvious and urgent threats posed by this growing pandemic. The over-800 people confined in the Jail are forced to suffer unconstitutional conditions that blatantly deny them the precautions and protections necessary to mitigate against the risks of COVID-19.

6. Human beings confined inside the Jail sleep within one to three feet of each other, are denied medical treatment or must wait several days to receive it, do not have adequate soap, and share multiple common areas without adequate supplies to clean them. They are shuffled from cell to cell with no regard for which people are symptomatic and which are not. They cannot protect themselves, including by practicing social distancing, and they do not have access to the necessary hygiene services and facilities to avoid infection, which puts them at imminent risk of substantial bodily harm and death.

7. People confined in jails and prisons must “be furnished with the basic

¹⁰ Aileen Wingblad, *23 Oakland County Jail inmates have confirmed COVID-19*, Oakland Press (Apr. 10, 2020), https://www.theoaklandpress.com/news/coronavirus/23-oakland-county-jail-inmates-have-confirmed-covid-19/article_9cb8f138-7b69-11ea-ab69-0f769f8495c1.html.

human needs, one of which is ‘reasonable safety.’” *Helling v. McKinney*, 509 U.S. 25, 33-34 (1993) (citations omitted). Yet Plaintiffs, as well as the class and subclasses they represent, all face imminent risk of serious injury or death once they are exposed to COVID-19 in the Jail. Starkly, in the midst of a public health crisis, the people currently confined at the Jail have no adequate safeguards against the severe threat of this novel coronavirus—all they ask is to be treated humanely while they are in Oakland County’s custody during this perilous time.

8. Because of the ongoing, systemic violations of Petitioners/Plaintiffs’ constitutional rights, Petitioners/Plaintiffs seek class-wide relief requiring Defendants to take basic and necessary steps to safeguard the health of people who, due to the nature of their confinement, are not only at heightened risk of infection and death but are also rendered unable to take the simple steps to protect themselves that have become a necessary part of everyday life for people not in jail. Petitioners/Plaintiffs further request a writ of habeas corpus for all those who are medically vulnerable and at particularly grave risk of infection and death from COVID-19 or, in the alternative, request an injunction requiring that they be transferred to home confinement for the duration of the COVID-19 pandemic.

JURISDICTION AND VENUE

9. This is a civil rights action arising under 42 U.S.C. § 1983, 28 U.S.C. § 2241, and 28 U.S.C. § 2201, *et seq.*, as well as the Eighth and Fourteenth

Amendments to the United States Constitution. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343, 28 U.S.C. § 2241, and 28 U.S.C. § 1651.

10. Venue is proper pursuant to 28 U.S.C. § 1391 because a substantial part of the events and omissions giving rise to these claims occurred and continue to occur in this judicial district.

PARTIES

11. Petitioner/Plaintiff Jamaal Cameron currently resides in Oakland County, Michigan. At all times relevant to this Complaint, Mr. J. Cameron was in the custody of Defendant Bouchard, in his capacity as Oakland County Sheriff, at the Jail. He suffers from bronchitis and hypertension. He also has sleep apnea, which he has not received treatment for since entering the Jail. He is housed in “the Tank,” a dank and crowded holding cell with no bunks, where he sleeps on the concrete floor in extremely close proximity to people who have symptoms of COVID-19. He was moved to the Tank, from another jail building with far fewer suspected cases of COVID-19, as punishment for raising concerns about the safety conditions in the jail. Mr. J. Cameron is in the Jail following conviction. He represents the Class, as well as the Post-conviction Subclass and Medically Vulnerable Subclass.

12. Petitioner/Plaintiff Richard Briggs currently resides in Oakland

County, Michigan. At all times relevant to this Complaint, Mr. Briggs was in the custody of Defendant Bouchard, in his capacity as Oakland County Sheriff, at the Jail. He is confined to the Jail because he cannot afford to pay his bond. He is awaiting trial and is presumptively innocent. He represents the Class, as well as the Pre-trial Subclass.

13. Petitioner/Plaintiff Raj Lee currently resides in Oakland County, Michigan. At all times relevant to this Complaint, Mr. Lee was in the custody of Defendant Bouchard, in his capacity as Oakland County Sheriff, at the Jail. He is housed in “the Tank,” a dank and crowded holding cell with no bunks, where he sleeps on the concrete floor in extremely close proximity to people who have symptoms of COVID-19. He was moved to the Tank, from another jail building with far fewer suspected cases of COVID-19, as punishment for raising concerns about the safety conditions in the Jail. He represents the Class, as well as the Post-conviction Subclass.

14. Petitioner/Plaintiff Michael Cameron currently resides in Oakland County, Michigan. At all times relevant to this Complaint, Mr. M. Cameron was in the custody of Defendant Bouchard, in his capacity as Oakland County Sheriff, at the Oakland County Jail. He suffers from cardiac disease, hypertension, and obesity. He is not able to get medical attention. He represents the Class, as well as the Post-conviction Subclass and Medically Vulnerable Subclass.

15. Petitioner/Plaintiff Matthew Saunders currently resides in Oakland County, Michigan. At all times relevant to this Complaint, Mr. Saunders was in the custody of Defendant Bouchard, in his capacity as Oakland County Sheriff, at the Jail. He cannot get medical attention and has not had access to soap for over a week. He is awaiting trial and is presumptively innocent. He represents the Class, as well as the Pre-trial Subclass.

16. Defendant Oakland County is a political subdivision of the State of Michigan that can be sued in its own name. Oakland County is responsible for all acts of the Oakland County Sheriff's Office. The Oakland County Sheriff's Office oversees and administers the Jail and is responsible for the custody and care of all persons detained or incarcerated in the Jail, and it currently has immediate custody over Petitioners/Plaintiffs and other putative class members.

17. Defendant Michael Bouchard is the Sheriff of Oakland County and is responsible for operating the Jail and maintaining the care and custody of people confined at the Jail. He is being sued in his official capacity.

18. Defendant Curtis Childs is the Commander of Corrective Services for the Oakland County Sheriff's Office and is responsible for operating the Jail. He is being sued in his official capacity.

THE GRAVE RISK OF HARM POSED BY THE COVID-19 PANDEMIC REQUIRES AN EMERGENCY RESPONSE

19. We are in the midst of an unprecedented global health emergency.¹¹ On March 11, 2020, the World Health Organization declared that the outbreak of COVID-19 constituted a global pandemic.¹² Citing “deep[] concern[] both by the alarming levels of spread and severity, and by the alarming levels of inaction,” it called for countries to take “urgent and aggressive action.”¹³

20. The number of people infected by COVID-19 is growing exponentially.¹⁴ On January 1, 2020, the first confirmed COVID-19 case was diagnosed in the United States.¹⁵ As of April 15, 2020, over half a million people

¹¹ See World Health Organization, Director-General Opening Remarks (Mar. 11, 2020), <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mediabriefing-on-covid-19---11-march-2020>.

¹² *Id.*

¹³ *Id.*; see also *Coronavirus: COVID-19 Is Now Officially A Pandemic, WHO Says*, NPR (March 11, 2020), <https://www.npr.org/sections/goatsandsoda/2020/03/11/814474930/coronavirus-covid-19-is-now-officially-a-pandemic-who-says>.

¹⁴ The death toll in Italy, which began experiencing this epidemic about a week earlier than the first diagnosed American case, saw a rise of 30% overnight in the 24 hours between March 5, 2020, and March 6, 2020 and a rise of 25% on March 15 alone—a day that killed 368 people in Italy. Crispian Balmer & Angelo Amante, *Italy coronavirus deaths near 200 after biggest daily jump*, Reuters (Mar. 6, 2020), <https://www.reuters.com/article/us-health-coronavirus-italy/italy-coronavirus-deaths-near-200-after-biggest-daily-jump-idUSKBN20T2ML>.

¹⁵ Derrick Bryson Taylor, *A Timeline of the Coronavirus*, New York Times (Mar. 2020), <https://www.nytimes.com/article/coronavirus-timeline.html> (last visited March 24, 2020).

have been diagnosed with COVID-19 in the United States, with 22,252 deaths confirmed.¹⁶ Nationally, CDC projections indicate that over 200 million individuals in the United States could be infected with COVID-19 over the course of the epidemic without effective public health intervention,¹⁷ with as many as 2.2 million deaths in the worst projections.¹⁸

21. COVID-19 is highly contagious. The virus is thought to spread through respiratory droplets or by touching a surface or object that has the virus on it.¹⁹ COVID-19 is thought to survive for three hours in the air in droplet form, up to twenty-four hours on cardboard, up to two days on plastic, and up to three days on steel.²⁰

22. Infected people—who may be asymptomatic and not even know they

¹⁶ *Coronavirus 2019*, Centers for Disease Control, <https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>.

¹⁷ James Glanz et al., *Coronavirus Could Overwhelm U.S. without Urgent Action, Estimates Say*, N.Y. Times (Mar. 20, 2020), <https://www.nytimes.com/interactive/2020/03/20/us/coronavirus-model-us-outbreak.html>.

¹⁸ Holly Yan, *More than 3,000 people in the US have died from coronavirus*, CNN (Mar. 31, 2020), <https://www.cnn.com/2020/03/30/health/us-coronavirus-updatesmonday/index.html>.

¹⁹ *Coronavirus Factsheet*, Centers for Disease Control (Mar. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf>.

²⁰ Neeltje van Doremalen et al., *Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1*, NEW ENGLAND J. MEDICINE (March 17, 2020), <https://www.nejm.org/doi/full/10.1056/NEJMc2004973>.

are infected—can spread the disease even through indirect contact with others.²¹

Given that many people are asymptomatic transmitters and very few people have been tested,²² the number of people diagnosed with COVID-19 reflects only a small portion of those infected.²³

23. Everyone is at risk of contracting the novel coronavirus disease, but certain populations are at higher risk for severe illness from COVID-19. People of any age with lung disease or other conditions like asthma, chronic liver or kidney disease, diabetes, epilepsy, hypertension, compromised immune systems, blood disorders, inherited metabolic disorders, stroke, and pregnancy face increased risk

²¹ See, e.g., Marilynn Marchione/AP, *Novel Coronavirus Can Live on Some Surfaces for Up to 3 Days, New Tests Show* TIME, (Mar. 11, 2020), <https://time.com/5801278/coronavirus-stays-on-surfaces-days-tests/>; Cai J et al., *Indirect virus transmission in cluster of COVID-19 cases, Wenzhou, China, 2020* Emerg Infect Dis. 6, 26 (2020), <https://doi.org/10.3201/eid2606.200412>.

²² Roni Caryn Rabin, *They Were Infected with the Coronavirus. They Never Showed Signs*, N.Y. Times (Feb. 26, 2020, updated Mar. 6, 2020), <https://www.nytimes.com/2020/02/26/health/coronavirus-asymptomatic.html>; Aria Bendix, *A Person Can Carry And Transmit COVID-19 Without Showing Symptoms, Scientists Confirm*, Bus. Insider (Feb. 24, 2020), <https://www.sciencealert.com/researchers-confirmed-patients-can-transmit-the-coronavirus-without-showing-symptoms>.

²³ Melissa Healy, *True Number of US Coronavirus Cases is Far Above Official Tally, Scientists Say*, L.A. Times (Mar. 10, 2020), <https://www.msn.com/en-us/health/medical/true-number-of-us-coronavirus-cases-is-far-above-official-tally-scientists-say/ar-BB110qoA>.

of serious COVID-19 disease.²⁴ Older individuals also face greater chances of serious illness or death from COVID-19.²⁵ For people over the age of 50 or with medical conditions that increase the risk of serious COVID-19 infection, symptoms such as fever, coughing, and shortness of breath can be especially severe.²⁶

24. COVID-19 can severely damage lung tissue (sometimes leading to a permanent loss of respiratory capacity), lead to acute respiratory distress syndrome, affect cardiac functions (including the possibility of heart failure), and cause widespread damage to other organs.²⁷ Emerging evidence also suggests that COVID-19 can trigger an over-response in the immune system and further damage the body's tissues or organs, including permanent harm to the kidneys or neurologic injury.²⁸

25. The experiences of those infected with COVID-19 are “a lot more

²⁴ Ex. 4, Expert Decl. of Dr. Jonathan Golob ¶ 4, *Dawson v. Asher*, Case No. 2:20-cv-00409-JLR-MAT, ECF Doc. 5 (D. Or. Mar. 16, 2020).

²⁵ Golob Decl. ¶ 3; Xianxian Zhao et al., *Incidence, clinical characteristics and prognostic factor of patients with COVID-19: a systematic review and meta-analysis* (Mar. 20, 2020), <https://cutt.ly/etRAkmt>.

²⁶ Golob Decl. ¶ 5; *see also* Ex. 5, Decl. of Dr. Carlos Franco Paredes, *Fraihat v. U.S. Immigration and Customs Enforcement*, 5:19-cv-01546-JGB-SHK, ECF Doc. 81-12 (E.D. Cal., Mar. 24, 2020) (outlining the heightened risk of severe harm or death for those populations deemed medically vulnerable to COVID-19, including higher fatality rates, severe damage to organs and other capacities, and the need for advanced support).

²⁷ Golob Decl. ¶ 7.

²⁸ *Id.*

frightening” than the flu.²⁹ The sensation of acute respiratory distress syndrome has been compared to “essentially drowning in [one’s] own blood.”³⁰ Even relatively young people with minimal health history can be “wiped out” by the virus, “like they’ve been hit by a truck,” and people who are infected by the virus can “all of a sudden” go into complete respiratory failure.³¹

26. These complications can manifest at an alarming pace, and the required levels of support can quickly exceed local health care resources.³² Patients with serious cases of COVID-19 will need advanced medical support requiring highly specialized equipment that is in limited supply, such as ventilator or oxygenation assistance, as well as an entire team of care providers that can include 1:1 nurse to patient ratios, respiratory therapists, and intensive care physicians.³³

27. The current estimated incubation period is between 2 and 14 days.³⁴ Approximately 20% of people infected experience life-threatening complications,

²⁹ Lizzie Presser, *A Medical Worker Describes Terrifying Lung Failure From COVID-19 — Even in His Young Patients*, Propublica (Mar. 21, 2020), <https://www.propublica.org/article/a-medical-worker-describes--terrifying-lung-failure-from-covid19-even-in-his-young-patients>.

³⁰ *Id.*

³¹ *Id.*

³² Golob Decl. ¶ 6; Stern Decl. ¶ 11.

³³ Golob Decl. ¶¶ 5-6.

³⁴ *Coronavirus Disease COVID-19 Symptoms*, Centers for Disease Control (Feb. 29, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html>.

and, of those infected, between 1% and 3.4% die.³⁵ According to recent estimates, the fatality of people infected with the coronavirus is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.³⁶ Patients who do not die from serious cases of COVID-19 may face prolonged recovery periods, including extensive rehabilitation from neurologic damage and loss of respiratory capacity.³⁷

28. There is no vaccine, nor is there any known medication to prevent or cure infection from the virus.³⁸ Development of a vaccine is likely at least 12 months away.³⁹

29. The only known effective measure to reduce the risk of severe illness or death to individuals is to prevent them from being infected with the coronavirus in the first place.⁴⁰ Accordingly, officials and experts urge “social distancing”—

³⁵ *Why Covid-19 is worse than the flu, in one chart*, Vox (Mar. 18, 2020), <https://www.vox.com/science-and-health/2020/3/18/21184992/coronavirus-covid-19-flu-comparison-chart>.

³⁶ Betsy McKay, *Coronavirus vs. Flu Which Virus is Deadlier*, WALL ST. J. (Mar. 10, 2020), <https://www.wsj.com/articles/coronavirus-vs-flu-which-virus-is-deadlier-11583856879>.

³⁷ Golob Decl. ¶ 4.

³⁸ Golob Decl. ¶ 8.

³⁹ Saralyn Cruickshank, *Experts Discuss Covid-19 and Ways to Prevent Spread of Disease*, John Hopkins Mag. (Mar. 17, 2020), <https://hub.jhu.edu/2020/03/17/coronavirus-virology-vaccinesocial-distancing-update>.

⁴⁰ Golob Decl. ¶ 8.

isolating oneself from other people at a minimum distance of six feet as much as possible.⁴¹ Dozens of the world’s experts on fighting epidemics agree that extreme social distancing approximates the type of “total freeze”⁴² to transmission that is vital to halting and reversing the spread of COVID-19. Epidemiologists say that “[i]f it were possible to wave a magic wand and make all Americans freeze in place for 14 days while sitting six feet apart . . . the whole epidemic would sputter to a halt.”⁴³

30. For this reason, governors and mayors across the country are ordering entire cities and states to “shelter in place” and “stay at home.”⁴⁴ Other federally recommended precautions include frequent hand-washing, alcohol-based hand sanitizers, and frequent cleaning *and* disinfecting of any surfaces touched by any

⁴¹ Michigan Executive Order 2020-21, (Mar. 24, 2020) https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-522626--,00.html; See Saralyn Cruickshank, *Experts Discuss Covid-19 and Ways to Prevent Spread of Disease*, John Hopkins Mag. (Mar. 17, 2020), <https://hub.jhu.edu/2020/03/17/coronavirus-virology-vaccine-social-distancing-update>.

⁴² Donald G. McNeil Jr., *The Virus Can Be Stopped, but Only With Harsh Steps, Experts Say*, N.Y. Times (Mar. 22, 2020), <https://www.nytimes.com/2020/03/22/health/coronavirus-restrictions-us.html>.

⁴³ *Id.*

⁴⁴ The governors of 42 states, as well as local officials of numerous counties in most remaining states, have all ordered residents to “shelter in place” or stay at home. See *Which States and Cities Have Told Residents to Stay at Home*, N.Y. Times (April 7, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html>.

person.⁴⁵

INCARCERATED PEOPLE AND CORRECTIONAL STAFF ARE AT HEIGHTENED RISK DURING THE COVID-19 PANDEMIC

31. Substantial epidemiological research “shows that mass incarceration raises contagion rates for infectious disease—both for people in jails, and for the community at large.”⁴⁶ During pandemics, jail facilities become “ticking time bombs” as “[m]any people crowded together, often suffering from diseases that weaken their immune systems, form a potential breeding ground and reservoir for diseases.”⁴⁷

32. Indeed, Dr. Meyer has explained that “the risk posed by COVID-19 in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected.”⁴⁸ This is

⁴⁵ *Steps to Prevent Illness*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/about/prevention.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fabout%2Fprevention-treatment.html; see also Saralyn Cruickshank, *Experts Discuss Covid-19 and Ways to Prevent Spread of Disease*, John Hopkins Mag. (Mar. 17, 2020), <https://hub.jhu.edu/2020/03/17/coronavirus-virology-vaccine-social-distancing-update>.

⁴⁶ Sandhya Kajeepeta & Seth J. Prins, *Why Coronavirus in Jails Should Concern All of Us*, The Appeal (Mar. 24, 2020), <https://theappeal.org/coronavirus-jails-public-health/>.

⁴⁷ See St. Louis Univ., *Prisons Unprepared For Flu Pandemic*, ScienceDaily (2006), <https://www.sciencedaily.com/releases/2006/09/060915012301.htm>.

⁴⁸ Meyer Decl. ¶ 7.

due to a number of factors, including:

- a. The close proximity of individuals in those facilities;
- b. Their reduced ability to protect themselves through social distancing;
- c. The lack of necessary medical and hygiene supplies ranging from hot water, soap or hand sanitizer, to protective equipment;
- d. Ventilation systems that encourage the spread of airborne diseases;
- e. Difficulties quarantining individuals who become ill;
- f. The enhanced susceptibility of the population in jails and prisons due to chronic health conditions;
- g. The fact that incarcerated people, rather than professional cleaners, are often responsible for cleaning the facilities and are not given appropriate supplies;
- h. The fact that jails and prisons normally have to rely heavily on outside hospitals that will become unavailable during a pandemic, as well as the loss of both medical and correctional staff to illness.⁴⁹

⁴⁹ See Meyer Decl. ¶¶ 7-19. “The pathway for transmission of pandemic influenza between jails and the community is a two-way street. Jails process millions of bookings per year. Infected individuals coming from the community may be housed with healthy inmates and will come into contact with correctional officers, which can spread infection throughout a facility.” *Pandemic Influenza & Jail Facilities & Populations*, Am. J. of Pub. Health, October 2009; see also Dr. Anne

33. Additional reasons for the increased risk of transmission and infection include the constant cycling of people in and out of the jail (including staff)⁵⁰ and insufficient access to medical care within the jail itself.

34. And jail screening procedures are ineffective. COVID-19 poses a particular threat to public health because a person can be asymptomatic yet spread the disease to others. Most people do not show symptoms for two to fourteen days while being contagious. Others never exhibit any symptoms at all. Thus, while screening for fevers and other symptoms associated with COVID-19 may stop some infected people from entering, it cannot catch many of those actively spreading the virus. The drastic social distancing measures that have been imposed across the country are designed exactly to combat this problem—staying at home, we are able to limit our contact with other persons, even the asymptomatic. But every day, numerous jail employees, working on multiple different shifts, travel into and out of the jail. Any one of those employees can be asymptotically carrying and transmitting COVID-19, and the jail has no means of stopping this disease vector.

35. In Michigan, more than 40 state department of corrections staff have

Spaulding, *Coronavirus and the Correctional Facility: for Correctional Staff Leadership* (Mar. 9, 2020), https://www.ncchc.org/filebin/news/COVID_for_CF_Administrators_3.9.2020.pdf.

⁵⁰ See Peter Wagner & Emily Widra, *No need to wait for pandemics: The public health case for criminal justice reform*, Prison Policy Initiative (Mar. 6, 2020), <https://www.prisonpolicy.org/blog/2020/03/06/pandemic>.

contracted COVID-19, and an additional 150 staff have self-quarantined due to possible exposure.⁵¹ On April 2, 2020, Andy Potter, executive director of the Michigan Corrections Organization, and Brian Dawe, executive director of the American Correctional Officer Intelligence Network, sent a letter to the National Governors Association, describing the dire impact of COVID-19 on correctional officers and staff⁵²: “[O]fficers in Michigan, New York and New Jersey have died from COVID-19. They will not be the last. Hundreds more across the nation have tested positive and thousands face quarantine. Inmates in our custody are dying as a result of this virus.” The letter also referenced a survey of over 750 correctional officers and staff about the ways in which the COVID-19 virus is impacting prisons, jails, and juvenile detention facilities, in which almost 60% of respondents said that COVID-19-related hazards inside their facility remain unaddressed.⁵³ Correctional officials around the country agree that particular care must be taken to stop the spread of COVID-19 within the nation’s jails. Leann Bertsch, the Director of the

⁵¹ Jameson Cook, *Michigan prison guards concerned about dangers of COVID-19*, Macomb Daily (Apr. 5, 2020), https://www.macombdaily.com/news/coronavirus/michigan-prison-guards-concerned-about-dangers-of-covid-19/article_1e6c27f6-7604-11ea-a444-43bddcfab230.html.

⁵² Letter from One Voice and ACOIN to National Governors Association (Apr. 2, 2020), https://drive.google.com/file/d/13euHXAPbSyVo1vkG9k1x7ymJC1_UJhTc/view.

⁵³ *Id.*

North Dakota Department of Corrections and Rehabilitation, concluded that “ignoring the health of those living and working inside the walls of our nation’s correctional facilities poses a grave threat to us all” and that “putting public health first is the best, and only, way to effectively achieve [a department of correction’s] public safety mission during the COVID-19 pandemic.”⁵⁴

36. The guidance from the Centers for Disease Control and Prevention (CDC) for correctional and detention facilities, including local jails, was published on March 30, 2020.⁵⁵ The guidance acknowledges that incarcerated people are forced to exist “within congregate environments” that “heighten[] the potential for COVID-19 to spread once introduced,” especially given the impossibility of social distancing within correctional facilities. It recognizes the “many opportunities for COVID-19 to be introduced into a correctional or detention facility” including “daily staff ingress and egress” as well as “high turnover” of “admit[ted] new entrants.”⁵⁶ In light of these concerns, the guidance recommends that the correctional facility:

⁵⁴ Brie Williams and Leanne Bertsch, *A public health doctor and head of corrections agree: we must immediately release people from jails and prisons*, The Appeal (Mar. 27, 2020), <https://theappeal.org/a-public-health-doctor-and-head-of-corrections-agree-we-mustimmediately-release-people-from-jails-and-prisons/>.

⁵⁵ Ex. 6, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, Centers for Disease Control and Prevention (Mar. 23, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidancecorrectional-detention.html>.

⁵⁶ *Id.*

- a. Post signage throughout the facility communicating COVID-19 symptoms and hand hygiene instructions, ensure such signage is understandable for non-English speaking people as well as those with low literacy, and provide clear information about the presence of COVID-19 cases within a facility and the need to increase social distancing and maintain hygiene precautions;
- b. Ensure sufficient stocks of hygiene and cleaning supplies, including tissues; liquid soap where possible; hand drying supplies; alcohol-based hand sanitizer; cleaning supplies effective against the coronavirus; and recommended personal protective equipment like face masks, disposable medical gloves, and N95 respirators;
- c. Provide incarcerated people no-cost access to soap (providing liquid soap where possible), running water, hand drying machines or disposable paper towels for hand washing, and tissues (providing no-touch trash receptacles for disposal);
- d. Consider relaxing restrictions on allowing alcohol-based hand sanitizer where security concerns allow;
- e. Provide a no-cost supply of soap sufficient to allow frequent hand washing, providing liquid soap where possible;
- f. Suspend co-pays for incarcerated people seeking medical evaluation for respiratory symptoms;
- g. Even if COVID-19 cases have not been identified locally or inside, implement “intensified cleaning and disinfecting procedures” that clean and disinfect high-touch surfaces and objects “[s]everal times per day,” and ensure adequate supplies to support intensified cleaning and disinfection practices”;
- h. Perform pre-intake screening and temperature checks for all new entrants
- i. If an individual has symptoms of COVID-19 (fever, cough, shortness of breath), require the individual to wear a face mask and place her under medical isolation;

- j. Implement social distancing strategies to increase the physical space between incarcerated people, ideally a distance of six feet “regardless of the presence of symptoms”; and
- k. Implement daily temperature checks in housing units where COVID-19 cases have been identified.

37. According to correctional health expert Dr. Marc Stern, this guidance sets out only minimum standards and fails to address the need for downsizing when necessary to ensure that social distancing can be maintained in the jail environment.⁵⁷

38. The global path of the virus confirms that jails and prisons are epicenters for transmission. Approximately one month into the pandemic in the province of Hubei, China, over half of reported COVID-19 cases were from jails.⁵⁸ In South Korea, which has had tremendous success in slowing and stopping the spread of the virus, “the single largest COVID-19 outbreak and mortality cluster was from the Daenam Prison Hospital, where 101 inmates were infected and seven died.”⁵⁹

⁵⁷ Stern Decl. ¶¶ 9–10.

⁵⁸ Zi Yang, *Cracks in the System: COVID-19 in Chinese Prisons*, Diplomat (Mar. 9, 2020), <https://thediplomat.com/2020/03/cracks-in-the-system-covid-19-in-chinese-prisons/>.

⁵⁹ Nancy Gertner & John Reinstein, *Compassionate Release Now for Prisoners Vulnerable to the Coronavirus*, Boston Globe (Mar. 23, 2020), <https://www.bostonglobe.com/2020/03/23/opinion/compassionate-release-now-prisoners-vulnerable-coronavirus/>.

39. The coronavirus has already started to spread inside other prisons, jails, and detention centers in the United States. Experts predict that a mass contagion is only a matter of time and that “[a]ll prisons and jails should anticipate that the coronavirus will enter their facility.”⁶⁰

40. Once the virus enters a jail or prison, the infection rate has been known to be much higher than in the broader community. In New York City, for example, the COVID-19 infection rate in the city’s jails is eight times higher than the rest of the city, which already sits at one of the highest rates in the world.⁶¹ The first case of COVID-19 on Rikers Island, New York City’s largest jail complex, was confirmed on March 18, 2020.⁶² In New York City, less than a month from the detection of the first case at Riker’s Island, 334 incarcerated people and 627 jail staff

⁶⁰ Evelyn Cheng & Huileng Tan, *China Says More than 500 Cases of the New Coronavirus Stemmed from Prisons*, CNBC, (Feb. 20, 2020), <https://www.cnbc.com/2020/02/21/coronavirus-china-says-two-prisons-reported-nearly-250-cases.html> (quoting Tyler Winkelman, co-director of the Health, Homelessness, and Criminal Justice Lab at the Hennepin Healthcare Research Institute in Minneapolis).

⁶¹ *COVID-19 Infection Tracking in NYC Jails*, *The Legal Aid Society NYC* (last visited Mar. 28, 2020), <https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/>.

⁶² *21 Inmates, 17 Employees Test Positive for COVID-19 on Rikers Island: Officials*, NBC New York (Mar. 22, 2020), <https://www.nbcnewyork.com/news/coronavirus/21-inmates17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242/>.

have tested positive⁶³; two jail officers have died; and more than 800 incarcerated people were held in isolation or quarantined.⁶⁴ The dramatic outbreak of COVID-19 in the Cook County Jail is also illustrative—126 staff and 298 detainees have tested positive for COVID-19 and nurses at Cook County’s Stroger Hospital have warned that the virus is a “growing beast” that threatens not only staff and people behind bars but all of Cook County.⁶⁵ An entire unit at Stroger Hospital has been converted into a space for treating COVID-19 cases from the Cook County jail, and the unit is rapidly reaching maximum capacity.⁶⁶

41. An equally gruesome pattern is already devastating Michigan’s carceral system.⁶⁷ In one Michigan prison alone, 10% of all incarcerated people have tested

⁶³ Jennifer Bisram, *Exclusive: NYC DOC commissioner addresses COVID-19 concerns on Rikers Island*, PIX 11 (Apr. 14, 2020), <https://www.pix11.com/news/coronavirus/exclusive-nyc-doc-commissioner-addresses-covid-19-concerns-on-rikers-island>

⁶⁴ Jay Ransom and Alan Feuer, ‘We’re Left for Dead’: Fears of Virus Catastrophe at Rikers Jail, N.Y. Times (Last updated: Mar. 31, 2020), <https://www.nytimes.com/2020/03/30/nyregion/coronavirus-rikers-nyc-jail.html>.

⁶⁵ Shannon Heffernan, *Nurses Warn COVID-19 Cases At Cook County Jail Aren’t Just Staying Behind Bars*, WBEZ, Chicago’s NPR (Apr. 11, 2020), <https://www.wbez.org/stories/nurses-warn-covid-19-cases-at-cook-county-jail-arent-just-staying-behind-bars/44cc1e46-693b-44cc-8a5a-347737966185>.

⁶⁶ *Id.*

⁶⁷ See Angie Jackson & Kristi Tanner, *Infection Rate at Michigan Prison Exceeds New York, Chicago Hot Spots*, Detroit Free Press (Apr. 15, 2020), <https://www.freep.com/story/news/local/michigan/2020/04/16/infection-rate-michigan-prison-exceeds-new-york-chicago-jail-hotspots/2987935001/>.

positive for COVID-19, and 9 prisoners have already died statewide.⁶⁸ As of April 15, there were 454 confirmed cases among people detained in Michigan's prisons, an increase of almost 200 cases from a week prior.⁶⁹ And 175 prison staff also had confirmed cases on April 15. There have also been numerous outbreaks in Michigan's jails, including in all three counties in the Detroit metropolitan area.⁷⁰

42. For this reason, medical and public health experts have urged emergency action to fight the spread of COVID-19 in jails and other carceral facilities, including decarceration, improved access to medical care, and compliance with CDC guidelines.⁷¹ And the World Health Organization has declared that no

⁶⁸ *Id.*

⁶⁹ See Mich. Dep't of Corrections, *Total Confirmed Prisoner and Staff Cases to Date* (last checked Apr. 15, 2020), <https://medium.com/@MichiganDOC/mdoc-takes-steps-to-prevent-spread-of-coronavirus-covid-19-250f43144337>; see also Egan & Jackson, *Coronavirus Spreads to 4 More Michigan Prisons As Concerns Mount*, Detroit Free Press (April 10, 2020), <https://www.freep.com/story/news/local/michigan/2020/04/10/coronavirus-covid-19-spreads-michigan-prisons/5133558002/>.

⁷⁰ See Ross Jones, *Michigan Prisons and Jails See COVID-19 Cases Rise*, WXYZ Channel 7 News (Apr. 3, 2020), <https://www.wxyz.com/news/local-news/investigations/michigan-prisons-and-jails-see-covid-19-cases-rise>.

⁷¹ See, e.g., Ex. 7, Brad Lander, *Doctors in NYC Hospitals, Jails, and Shelters Call on the City to Take More Aggressive Action to Combat the Spread of Coronavirus*, Medium (Mar. 12, 2020), <https://medium.com/@bradlander/doctors-in-nyc-hospitals-jails-and-shelters-call-on-the-city-to-take-more-aggressive-action-to-fb75f0b131c2>; Ex. 8, Letter from Johns Hopkins faculty to Governor Hogan, Mar. 25, 2020, <https://bioethics.jhu.edu/wp-content/uploads/2019/10/JohnsHopkins-faculty-letter-on-COVID-19-jails-and-prisons.pdf>; Stern Decl. ¶ 11; Ex. 9, Decl. of Dr. Ranit Mishori ¶ 46, *Coreas v. Bounds*, et al., No. 8:20-cv-00780, ECF Doc. 2-3

government should end a “shelter in place” or lockdown procedure until “hot spot risks are minimized in vulnerable places,” which includes jails and prisons.⁷² Medical experts explain that the need for action is urgent given that “[t]he window of opportunity is rapidly narrowing for mitigation of COVID-19”—outbreaks are measured “in a matter of days, not weeks,” with this type of novel virus.⁷³

43. Numerous public health experts, including Plaintiffs’ expert Dr. Marc Stern,⁷⁴ Dr. Gregg Gonsalves,⁷⁵ Ross MacDonald,⁷⁶ Dr. Oluwadamilola T. Oladeru

(D. Md. Mar. 24, 2020); Ex. 10, Decl. of Robert B. Greifinger ¶ 13, *Dawson v. Asher*, Case No. 2:20-cv-00409-JLR-MAT, ECF Doc. 4 (D. Or., Mar. 16, 2020).

⁷² Bill Chappell, *WHO Sets 6 Conditions For Ending a Lockdown*, NPR (Apr. 15, 2020), https://www.npr.org/sections/goatsandsoda/2020/04/15/834021103/who-sets-6-conditions-for-ending-a-coronavirus-lockdown?utm_source=facebook.com&utm_campaign=npr&utm_medium=social&utm_term=nprnews&fbclid=IwAR34AVrfEfUkggt7aI2W_apYjtIK8XKObFnQkFNfAtsn9iWFLPj7VMnAfWU.

⁷³ Mishori Decl. ¶ 46.

⁷⁴ Stern Decl. ¶ 11.

⁷⁵ Kelan Lyons, *Elderly Prison Population Vulnerable to Potential Coronavirus Outbreak*, Connecticut Mirror (March 11, 2020), <https://cutt.ly/BtRSxCF>.

⁷⁶ Craig McCarthy and Natalie Musumeci, *Top Rikers Doctor: Coronavirus ‘Storm is Coming,’* N.Y. Post (Mar. 19, 2020), <https://cutt.ly/ptRSnVo>.

and Adam Beckman,⁷⁷ Dr. Anne Spaulding,⁷⁸ Homer Venters,⁷⁹ and Josiah Rich⁸⁰ 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.

44. According to Dr. Stern, “taking immediate and concerted efforts to implement preventive steps, as well as reducing the population to the lowest number possible prioritizing those who are elderly or have underlying medical conditions defined by the CDC, will increase public safety via reducing public health risk.”⁸¹

45. Given this urgency, jails and prisons nationwide have released people with the aim of preventing community outbreaks of severe illness and death from COVID-19. States and counties that have released people from incarceration in response to the COVID-19 crisis include, but are not limited to: Los Angeles County,

⁷⁷ Oluwadamilola T. Oladeru et al., *What COVID-19 Means for America’s Incarcerated Population – and How to Ensure It’s Not Left Behind* (Mar. 10, 2020), <https://cutt.ly/QtRSYNA>.

⁷⁸ Anne C. Spaulding, MD MPDH, *Coronavirus COVID-19 and the Correctional Jail*, Emory Center for the Health of Incarcerated Persons (Mar. 9, 2020).

⁷⁹ Madison Pauly, *To Arrest the Spread of Coronavirus, Arrest Fewer People*, Mother Jones (March 12, 2020), <https://cutt.ly/jtRSPnk>.

⁸⁰ Amanda Holpuch, *Calls Mount to Free Low-risk US Inmates to Curb Coronavirus Impact on Prisons*, The Guardian (Mar. 13, 2020), <https://cutt.ly/itRSDNH>.

⁸¹ Stern Decl. ¶ 13.

California (1,700 people);⁸² New York (more than 1,100 people);⁸³ New Jersey (1,000 people);⁸⁴ and Cuyahoga County, Ohio (approx. 600 people),⁸⁵ among others.

46. Internationally, governments have also responded to the threat posed by COVID-19 by releasing people from incarceration. In Iran, more than 80,000 people were temporarily released from prison to protect them and to protect the community from propagation of an outbreak.⁸⁶ In Ethiopia, more than 4,000 people were pardoned and released from incarceration to help prevent the spread of

⁸² *LA County Releases 1,700 Inmates to Reduce Jail Population Due to Coronavirus*, NBC Los Angeles (Mar. 24, 2020), <https://www.nbclausangeles.com/news/local/la-county-releases-1700inmates-to-reduce-jail-population-due-to-coronavirus/2334809/>.

⁸³ Brendan Lyons, *NY to release 1,100 parole violators as coronavirus spreads*, Times Union (Mar. 27, 2020), <https://www.timesunion.com/news/article/Deaths-surge-again-in-New-Yorkfrom-coronavirus-15160973.php>.

⁸⁴ *1,000 Inmates Will Be Released From N.J. Jails to Curb Coronavirus Risk*, N.Y. Times (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/nyregion/coronavirus-nj-inmates-release.html>.

⁸⁵ Scott Noll, *Cuyahoga County Jail releases hundreds of low-level offenders to prepare for coronavirus pandemic*, News 5 Cleveland (Mar. 20, 2020), <https://www.news5cleveland.com/news/local-news/oh-cuyahoga/cuyahoga-county-jail-releaseshundreds-of-low-level-offenders-to-prepare-for-coronavirus-pandemic>.

⁸⁶ Parisa Hafezi, *Iran Temporarily Frees 85,000 From Jail Including Political Prisoners*, Reuters (Mar. 17, 2020), <https://www.reuters.com/article/us-health-coronavirus-iran-prisoners/iran-temporarily-frees-85000-from-jail-including-political-prisoners-amid-coronavirus-idUSKBN21410M>.

COVID-19.⁸⁷

47. States and other local jurisdictions have also made changes to existing carceral policies in response to the COVID-19 pandemic, including eliminating medical co-pays for incarcerated people and waiving fees for phone calls and video communication.⁸⁸ Others have required facilities to distribute and make available sanitation supplies and hand sanitizer to everyone who is incarcerated, arranged for the immediate evaluation and treatment of anyone with symptoms, and enacted screening procedures for everyone who enters the jail or prison.⁸⁹

48. Over the past two weeks, multiple courts have also acknowledged the severe and urgent threats posed by COVID-19 and have accordingly ordered the release of detained and incarcerated persons.⁹⁰

⁸⁷ Bukola Adebayo, *Ethiopia pardons more than 4,000 prisoners to help prevent coronavirus spread*, CNN (Mar. 26, 2020), <https://www.cnn.com/2020/03/26/africa/ethiopia-pardons-4000-prisoners-over-coronavirus/index.html>.

⁸⁸ *Responses to the COVID-19 Pandemic*, Prison Policy (Mar. 27, 2020), <https://www.prisonpolicy.org/virus/virusresponse.html>.

⁸⁹ See, e.g., *Preparedness and Response Plan 5-8*, Indiana Dep't of Correction (2020), <https://www.in.gov/idoc/files/IDOC%20Pandemic%20Response%20Plan%203-3-2020.pdf#response%20plan>.

⁹⁰ See, e.g., *Castillo et al. v. Barr*, 5:20-cv-00605, ECF Doc. 32 (C.D. Cal. Mar. 27, 2020) (ordering petitioners be released from immigration detention in light of COVID-19 and noting “the risk of infection in immigration detention facilities – and jails – is particularly high”); *USA v. Garlock.*, No. 18 Cr 00418, 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020) (ordering, sua sponte, extension of convicted defendant’s surrender date and noting “[b]y now it almost goes without

**THE COVID-19 PANDEMIC HAS REACHED OAKLAND COUNTY AND
SWIFT ACTION IS NEEDED TO PREVENT A MASS OUTBREAK IN
THE JAIL**

49. With over 27,000 confirmed cases of COVID-19,⁹¹ the state of Michigan now ranks third in the country for COVID-19 related deaths trailing behind New York and New Jersey.⁹² Oakland County has the second highest number of COVID-19 cases in the state. As of April 16, 2020, over 5,000 people have been diagnosed with COVID-19 in Oakland County, with 392 deaths

saying that we should not be adding to the prison population during the COVID-19 pandemic if it can be avoided”); *Xochihua-Jaimes v. Barr*, No. 18-71460 (9th Cir. Mar. 24, 2020) (ordering, sua sponte, that petitioner be immediately released from immigration detention “[i]n light of the rapidly escalating public health crisis” related to COVID-19 that “public health authorities predict will especially impact immigration detention centers”); *U.S. v. Stephens*, 15 Cr. 95 (AJN), 2020 WL 1295155 (S.D.N.Y. Mar. 19, 2020) (granting motion for reconsideration of defendant’s bail conditions and releasing him from jail to home confinement, explaining that “the unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic has become apparent” and that “inmates may be at a heightened risk of contracting COVID-19 should an outbreak develop”); *In re. Extradition of Alejandro Toledo Manrique*, 2020 WL 1307109, (N.D. Cal. March 19, 2020) (ordering release on bond despite government assertions that facility has preparedness plan in place and no cases have been confirmed).

⁹¹ *Coronavirus Daily Counts*, Michigan.Gov (Apr. 15, 2020), https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173_99207---,00.html.

⁹² Bobby Allyn, *After Surge In Cases, Michigan Now 3rd In Country For Coronavirus Deaths*, NPR (Mar. 31, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/03/31/824738996/after-surge-in-cases-michigan-now-3rd-in-country-for-coronavirus-deaths>.

confirmed.⁹³

50. The Governor of Michigan declared a state of emergency on March 10, 2020, after two positive cases of COVID-19 were confirmed in Michigan—one in Oakland County and the other in Wayne County.⁹⁴ On March 13, 2020, Oakland County Executive David Coulter declared a local state of emergency as a response to the threat posed by COVID-19. In the emergency order, county health officer Leigh-Anne Stafford cautioned that the “best way to prevent infection is to avoid being exposed to the virus.”⁹⁵

51. On March 15, 2020, the Michigan Supreme Court issued Administrative Order 2020-1 instructing all trial courts in Michigan to take all “reasonable measures to avoid exposing participants in court proceedings, court employees, and the general public to the COVID-19 virus.” The order further instructs courts to reduce jail populations by “tak[ing] into careful consideration

⁹³ *Coronavirus*, Michigan.Gov, https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html.

⁹⁴ *Michigan Executive Order No. 2020-04 Declaration of State of Emergency*, (Mar. 10, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-521576--,00.html.

⁹⁵ *County Executive Coulter Continues Public Health Preparedness and Activates Emergency Operations Center for Coronavirus Efforts*, Oakland County News Release (Mar. 11, 2020), <https://www.oakgov.com/health/news/Documents/Press%20Releases/031020%20DRAFT%20COVID-19%20partial%20EOC%20HC%20+%20OCHD%20team.pdf>.

public health factors arising out of the present state of emergency” in making bond determinations and determining conditions or probation.

52. On March 16, 2020, Oakland County issued another order to reduce the occupancy load at county establishments, entertainment venues, and fitness centers by 50%, and county health officer Stafford reemphasized that “social distancing is vital” to keep residents healthy and “stop the spread of illness.”⁹⁶

53. On March 23, 2020, Governor Whitmer issued a statewide stay-at-home order and ordered all non-essential businesses to close to bolster efforts to fight the ongoing COVID-19 outbreak.⁹⁷

54. On March 26, 2020, Michigan Supreme Court Chief Justice Bridget M. McCormack and Sheriff Matt Saxton, Executive Director of the Michigan Sheriffs’ Association, issued a joint statement urging Judges and Sheriffs “to reduce and suspend jail sentences for people who do not pose a public safety risk” and “release far more people on their own recognizance as they await their day in court,” emphasizing that “[f]ollowing this advice WILL SAVE LIVES” during this global

⁹⁶ *Emergency Order For Control Of Pandemic*, Oakland County News Release (Mar. 14, 2020), <https://www.oakgov.com/Documents/News/Emergency%20Order%20for%20Coronavirus%20Pandemic%20food%20service%20establishments%20%203.14.20.pdf>

⁹⁷ Michigan Executive Order No. 2020-21 Temporary requirement to suspend activities that are not necessary to sustain or protect life (Mar. 23, 2020), https://content.govdelivery.com/attachments/MIEOG/2020/03/23/file_attachments/1408152/EO%202020-21%20Stay%20Home,%20Stay%20Safe.pdf

pandemic.⁹⁸

55. On March 29, 2020, Governor Whitmer issued Executive Order 2020-29⁹⁹, underscoring the life-or-death threat that the COVID-19 pandemic poses to people incarcerated in county jails throughout Michigan, as well as to jail staff and the community at large. The order detailed necessary protocols that the Michigan Department of Corrections, county jails, local lockups, and juvenile detention centers must implement to reduce exposure risks to the virus. These protocols include:

- a. “Screening all persons arriving at or departing from a facility, including staff, incarcerated persons, vendors, and any other person entering the facility, in a manner consistent with guidelines issued by the Centers for Disease Control and Prevention (‘CDC’). Such screening includes a temperature reading and obtaining information about travel and any contact with persons under investigation for

⁹⁸ *Michigan Court News Release* (Mar. 26, 2020), [https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20\(003\).pdf](https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20(003).pdf).

⁹⁹ Ex. 11, Michigan Executive Order No. 2020-29 Temporary COVID-19 protocols for entry into Michigan Department of Corrections facilities and transfers to and from Department custody; temporary recommended COVID-19 protocols and enhanced early-release authorization for county jails, local lockups, and juvenile detention centers Declaration of State of Emergency (Mar. 29, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523422--,00.html.

COVID-19 infection.”;

- b. “Restricting all visits, except for attorney-related visits, and conducting those visits without physical contact to the extent feasible.”;
- c. “Limiting off-site appointments except for urgent or emergency medical treatment”;
- d. “Developing and implementing protocols for incarcerated persons who display symptoms of COVID-19, including methods for evaluation and processes for testing, notification of the Department of Health and Human Services (“DHHS”), and isolation during testing, while awaiting test results, and in the event of positive test results. These protocols should be developed in consultation with local public health departments.”;
- e. “Notifying DHHS of any suspected case that meets the criteria for COVID-19 through communication with the applicable local public health department.”;
- f. “Providing, to the fullest extent possible, appropriate personal protective equipment to all staff as recommended by the CDC.”;
- g. “Conducting stringent cleaning of all areas and surfaces, including frequently touched surfaces (such as doorknobs, handles, light

switches, keyboards, etc.), on a regular and ongoing basis.”;

- h. “Ensuring access to personal hygiene products for incarcerated persons and correctional staff, including soap and water sufficient for regular handwashing.”;
- i. “Ensuring that protective laundering protocols are in place.”;
- j. “Posting signage and continually educating on the importance of social distancing, handwashing, and personal hygiene.”;
- k. “Practicing social distancing in all programs and classrooms—meaning a distance of at least six feet between people in any meeting, classroom, or other group.”; and
- l. “Minimizing crowding, including interactions of groups of 10 or more people, which may include scheduling more times for meal and recreation to reduce person-to-person contact.”

56. Many of the measures listed in the Governor’s Executive Order have not been implemented at the Jail.¹⁰⁰

57. Indeed, the Jail has failed to cooperate with courts and attorneys on common-sense measures to reduce incarceration rates. In particular, the Jail has refused to facilitate providing attorneys to newly arrested arrestees at their

¹⁰⁰ <https://www.oakgov.com/sheriff/Corrections-Courts/jail/Pages/default.aspx>.

arraignment. The standards promulgated by the Michigan Indigent Defense Commission (MIDC), as well as the Sixth Amendment, require that defendants be represented at their arraignments. Since the crisis, Defendants have refused to cooperate with the MIDC and with Oakland County courts to facilitate appearances of defense attorneys at arraignments. As a result, new arrestees face a heightened risk of being unjustly detained in the Jail under the conditions described herein because of being denied access to counsel at their arraignment. No other Jail in Michigan has exhibited similar unwillingness to provide counsel at arraignments during the crisis.

58. Executive Order 2020-29 also suspends the capacity and procedural requirements of Michigan's County Jail Overcrowding Act ("JOA"), thus empowering sheriffs and courts to swiftly but safely take bold and urgent steps to dramatically reduce jail populations to alleviate these risks. On March 31, 2020, the ACLU of Michigan and the State Appellate Defender Office sent letters to every chief judge and sheriff in the state, including Defendant Bouchard, outlining the specific measures that sheriffs and courts can now take to further reduce jail populations under the JOA, as modified by Executive Order 2020-29, while maintaining public safety.¹⁰¹ The letter called, *inter alia*, for 1) the release of pre-

¹⁰¹ Ex 12, Letter from ACLU to Chief Judges, Mar. 31, 2020, https://www.aclumich.org/sites/default/files/field_documents/aclu_letter_to_judges

trial detainees on a personal bond; 2) the release of prisoners who have served 85% of their sentences; 3) the reduction or suspension of sentences for other prisoners; and 4) a moratorium on detaining new people in the jails in order to reduce the risk of fatal COVID-19 outbreaks in the jails. Neither Defendant Bouchard nor the Oakland County Circuit Court have taken full advantage of the powers now available to them to reduce the jail population under the JOA.

59. On April 1, 2020, the Michigan Joint Task Force on Jail and Pretrial Incarceration issued a press release highlighting the gravity of a potential outbreak in county jails: “As high traffic institutions characterized by relatively confined spaces, the threat of COVID-19 is particularly acute in our county jails. Individuals in jail, including law enforcement and correctional officers, are at an elevated risk of being exposed to the virus and spreading it to others through inadequate social distancing.” The Task Force urged “justice system decision makers to continue taking all necessary actions to keep our communities safe through arrest alternatives, de-incarceration as appropriate, and social distancing.”¹⁰²

_re_gov_executive_order.pdf; Ex 13, Letter from ACLU to Sheriffs, Mar. 31, 2020 https://www.aclumich.org/sites/default/files/field_documents/aclu_letter_to_mi_sheriffs_re_gov_executive_order.pdf

¹⁰² *Michigan Joint Task Force on Jail and Pretrial Incarceration, Jail Population Reduction to Curb the Spread of COVID-19* (Apr. 1, 2020), https://courts.michigan.gov/News-Events/press_releases/Documents/Jails%20Task%20Force%20press%20release%20on%20COVID-19_FINAL.pdf

60. Yet, despite the urgent calls to reduce jail populations, Defendants have failed to take sufficient steps to reduce the population at the Jail to a safe number. To the contrary, as of April 3, 2020, public reports stated that only 60 people had been approved for early release from the Jail and that the only people even being considered for release were people with an underlying health condition or a bond of less than \$1,000.¹⁰³ Further, Defendants remain woefully unprepared and incapable of taking necessary precautions to protect the people currently confined in the Jail against this unprecedented, life-threatening public health crisis

61. Alarming, Michigan's coronavirus case count is doubling every three days,¹⁰⁴ and Governor Whitmer confirmed during a press conference on April 6, 2020, that the state is nowhere close to hitting the apex of the COVID-19 pandemic.¹⁰⁵ Hospitals in Southeast Michigan are already suffering and struggling

¹⁰³ Aileen Wingblad, *6 inmates at Oakland County Jail have COVID-19*, Oakland Press (Apr. 3, 2020), https://www.theoaklandpress.com/news/coronavirus/6-inmates-at-oakland-county-jail-have-covid-19/article_a1fe7b48-75df-11ea-ae6b-233d4bf6a9fe.html.

¹⁰⁴ Kristen Jordan Shamus and Kristi Tanner, *'Southeast Michigan is burning': Michigan's coronavirus case count doubles every 3 days*, Detroit Free Press (Mar. 29, 2020), <https://www.freep.com/in-depth/news/local/michigan/2020/03/28/michigan-coronavirus-surge-covid-19-case-count/2898574001/>.

¹⁰⁵ Courtney Vinopal, *WATCH: Michigan Gov. Gretchen Whitmer gives coronavirus update*, PBS (Apr. 6, 2020), <https://www.pbs.org/newshour/health/watch-live-michigan-gov-gretchen-whitmer-gives-coronavirus-update>.

to keep up with the rush of COVID-19 related patients.¹⁰⁶ The state's chief medical officer, Dr. Joneigh Khaldun, declared during the conference that state hospitals are overwhelmed because there are no signs that the rate of infection is slowing down.¹⁰⁷ A mass outbreak at the Jail would further cripple the already fragile healthcare system in Michigan. As early as March 23, Oakland County Executive David Coulter was already warning that he was hearing from all of Oakland County's hospitals that they were "already at a critical point" and that "this is going to get worse before it gets better."¹⁰⁸ And, just yesterday, the grisly news was reported that the County is scouting out ice rinks to store the bodies of the dead because of the potentially excessive number of fatalities that could occur in the upcoming weeks in the county's hospitals.¹⁰⁹

¹⁰⁶ See, e.g., Kristen Jordan Shamus & Darcie Moran, *Nurses Protest Conditions at Detroit's Sinai-Grace, Said They Were Told to Leave*, Detroit Free Press (Apr. 6, 2020), https://www.freep.com/story/news/health/2020/04/06/detroit-dmc-sinai-grace-nurses/2953385001/?utm_source=oembed&utm_medium=onsite&utm_campaign=storylines&utm_content=news&utm_term=4566614002.

¹⁰⁷ *Id.*

¹⁰⁸ Robin Erb, *Alarm Grows as Michigan Hospitals Begin to Fill with Coronavirus Cases*, Bridge (Mar. 23, 2020), <https://www.bridgemi.com/michigan-health-watch/alarm-grows-michigan-hospitals-begin-fill-coronavirus-cases>.

¹⁰⁹ Jennifer Dixon, *Oakland County Scouts Ice Rinks to Potentially Store Bodies in 'Last Resort' Scenario*, Detroit Free Press (Apr. 14, 2020), <https://www.freep.com/story/news/local/2020/04/15/coronavirus-oakland-ice-rinks-bodies/5137771002/>.

**DEFENDANTS' RESPONSES TO THE COVID-19 PANDEMIC ARE
CONSTITUTIONALLY DEFICIENT AND PLACE THE PEOPLE IN ITS
CUSTODY AT HEIGHTENED RISK**

62. All people incarcerated in the Jail face a significant risk of exposure to COVID-19. Defendants are well aware of the heightened threat of COVID-19 in the jails—the CDC, the Governor, medical experts, and various advocates have already alerted them of this risk as well as the preventive measures needed to protect against the further spread of COVID-19.

63. Currently in the Jail, people are forced to sleep in bunks that are one to three feet apart, and sometimes on a concrete floor right next to others, as in the case of Plaintiffs Lee and J. Cameron. People are also forced to share communal showers, toilets, and sinks in small common areas. Some bunks, like Plaintiff Briggs' are right next to the shared toilets.

64. People confined in the Jail are not given the opportunity to practice safe social distancing, and they are forced to sit, stand, walk, eat, and sleep within six feet of other people throughout the day.

65. People confined in the Jail are not provided with soap on a regular basis, and some people like Plaintiff Saunders have been without soap for over a week. Other personal sanitation supplies are not provided at all, and the commissary is closed, so there is no way to purchase them.

66. Defendants have also not provided access to hand sanitizer to

incarcerated people, but have provided it to their employees..

67. Staff do not consistently wear protective personal equipment like gloves or masks when interacting with people confined in the Jail, and there have been shortages in protective personal equipment for all people incarcerated and for people working in the Jail.

68. People confined in the Jail are not provided adequate cleaning supplies in the proper concentrations of strength to prevent transmission of the virus at no cost to them. Even basic cleaning supplies are difficult to come by. People incarcerated in the Jail have attempted to clean toilets with heavily diluted cleaning solution and toilet paper. There is no access to Kleenex.

69. The people tasked with cleaning cells or communal areas are not provided the protective personal equipment they need, such as masks or gloves, which would allow them to protect themselves from the virus. When gloves are provided, they are in scarce supply and people are forced to reuse them for multiple days, practically eliminating any protective benefit in slowing virus transmission.

70. Nor are people confined in the Jail provided adequate cleaning supplies to clean their own cells or living spaces, ensuring that the dozens of people who share the same cell will quickly transmit the illness to each other.

71. Defendants have provided neither paper towels nor other means for inmates to dry their hands after washing them. As a result, people who are detained

must shake their hands dry or wipe them on their jail-issued uniforms, which are exposed to contaminated surfaces and laundered infrequently (due to lack of access or cost).

72. Prior to the COVID-19 pandemic, nurses made rounds in the mornings and distributed “kites”¹¹⁰ so that people could request medical attention. When the pandemic began, the nurses ignored the requests for days at a time. As the pandemic progresses, the nurses do not even make rounds to distribute kites so that people can request medical attention if necessary. When people finally meet with a medical professional, proper care is not provided. For example, Plaintiff Saunders went to the medical ward with COVID-19 symptoms about a month ago. While there, he went eight to twelve hours with nobody coming to check on him at all. He could not move to get his meals, which were placed just inside the door. The meals were then simply removed with no attempt to bring them to him. Other people who have been exposed to those with presumed COVID-19, have been given a 7-day supply of Tamiflu with instructions to take it if they develop symptoms. Plaintiff Briggs attempted to get medical treatment by telling a nurse that he was experiencing shortness of breath. The nurse responded that he could not be speaking if he had shortness of breath and refused to treat or test him.

¹¹⁰ People incarcerated at the Jail request medical attention by completing “kites,” which are written requests to see a doctor or nurse.

73. People confined in the Jail are generally required to pay a \$12 co-pay for each visit to the doctor, when the visit finally occurs. The people in the Jail are not provided with access to their account statements, so they do not know if these co-pays are waived for COVID-19 treatment.

74. When people begin to show symptoms of COVID-19, such as a dry cough, shortness of breath, or a fever, they are not immediately tested or quarantined, if they are tested or quarantined at all.

75. While some people who are incarcerated in the Jail have been “quarantined” for presumed COVID-19, the quarantined cells are immediately next to cells that are not quarantined. People are so close to the “quarantined” cells that they can reach into these neighboring cells through the bars on the front of their own cells. People are also shuffled from quarantined cells into non-quarantined cells at random.

76. All the people incarcerated in the Jail use shared phones when calling family members, loved ones, or lawyers. The phones are not cleaned between each use, nor are people provided with disinfectant supplies, which means that each person must risk COVID-19 infection when touching and speaking through the phone.

77. The nurses are not consistently making rounds, and Plaintiff J. Cameron was told that no doctor would be available until May. When people express to

guards that they need medical treatment, the guards tell them that they must wait for a nurse. When the people remind the guards that the nurses are not coming, the guards tell them that there is nothing that they can do to help.

78. Not only are Defendants aware of the conditions in the Jail, but jail staff are actively using exposure to COVID-19 as a punitive measure to control incarcerated people. It is well known by both guards and incarcerated people at the Jail that the COVID-19 outbreak is centered in the main building. Guards in the annex have repeatedly threatened to move people in the annex who raise concerns about the hygienic conditions there into the main building where they will be exposed to COVID-19. In fact, both Plaintiff J. Cameron and Plaintiff Lee were punished in exactly this manner and were moved from the annex into the Tank as retaliation for raising concerns about their health. In the crowded Tank, they are required to sleep on the concrete floor right next to other incarcerated people in a cell that is within arm's reach of a similarly dungeon-like cell where quarantined COVID-19 patients are being warehoused.

79. The danger posed by Plaintiffs' incarceration during the COVID-19 pandemic is "so grave that it violates contemporary standards of decency to expose anyone unwillingly to such a risk" and violates their constitutional right to safety in government custody. *See Helling v. McKinney*, 509 U.S. 25, 36 (1993).

80. To expose people to the unmitigated risk of contracting COVID-19 is

constitutionally impermissible. Failure to act in accordance with speed and urgency will constitute a wholesale violation of the constitutional rights of those confined in the jail.

IMMEDIATE RELEASE OF THE MEDICALLY VULNERABLE IS THE ONLY RESPONSE THAT SERVES PUBLIC HEALTH, COMMUNITY SAFETY, AND THE INDIVIDUAL SAFETY OF EACH SUBCLASS MEMBER

81. Immediate release of medically vulnerable Plaintiffs, as well as the subclass of medically vulnerable people they represent, remains a necessary public health intervention.¹¹¹

82. Release is needed to prevent irreparable harm to members of the medically vulnerable subclass. Because of the rapidity with which COVID-19 spreads and the danger it poses, immediate release is both necessary and the least intrusive intervention to ensure Medically Vulnerable Class Members are provided medically and constitutionally sufficient treatment.

83. If immediate action is not taken to dramatically reduce the population

¹¹¹ Stern Decl. ¶¶ 10-11 (noting that “[d]ownsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to “flatten the curve” overall—both within the jail setting and without); Ex 14, Declaration of Dr. Adam Luring ¶ 37 (explaining that “drastically reducing the jail’s population is the only way to protect the health and safety of people detained in the facility and the public at large”); *see also* Meyer Decl. ¶¶ 37–38 (noting that population reduction in jails will be “crucially important to reducing the level of risk both for those within [jail] facilities and for the community at large,” and that stemming the flow of intakes is a part of the necessary intervention).

of the Jail, all people who remain incarcerated will be at grave and unacceptable risk of contracting COVID-19—a serious and potentially life-threatening illness. People confined in prisons and jails must “be furnished with the basic human needs, one of which is ‘reasonable safety,’” *Helling v. McKinney*, 509 U.S. 25, 33-34 (1993) (citations omitted), which is virtually impossible given the realities of the COVID-19 pandemic and the limitations inherent to the Jail.

84. The Jail is ill-equipped to manage or handle a COVID-19 outbreak—which is already occurring. The Jail lacks the ability to provide ICU-level care or access to ventilator equipment necessary to properly treat people who become infected. It does not have COVID-19 tests available for incarcerated people, and it has routinely refused offering such tests to people who exhibit known symptoms of the coronavirus. Over ten (and sometimes nearly 30) people are packed into the same cells, where people are forced into conditions where they sleep one to two feet away from another person, must share a limited supply of communal toilets, sinks, showers, furniture, and phones, and are not provided the hygiene and sanitation supplies necessary to adequately disinfect or clean their immediate surroundings, including all the high-touch surfaces and objects they are constantly forced to come into contact with.

85. Given the size of the Jail, the configuration of its cells, and staffing, the jail population must be significantly decreased to ensure adequate social distancing.

86. As Plaintiffs' expert declarant Dr. Marc Stern, a correction health expert who advises the National Sheriffs' Association and the U.S. Department of Justice, and who has served as Assistant Secretary of Healthcare for the Washington Department of Corrections has concluded: In this unique moment, release *enhances* the safety of other people and the community and is necessary to protect the Plaintiff's own health and safety.¹¹² And those Petitioners/Plaintiffs who remain incarcerated must be able to exercise self-protective measures in a sanitary, disinfected space, and to maintain social distance from other community members to flatten the curve of the virus's spread and protect themselves from infection.

87. Other medical experts specializing in correctional health similarly shared urgent recommendations to dramatically reduce the population of detention centers, jails, and prisons. Dr. Ranit Mishori, Senior Medical Consultant for Physicians for Human Rights and an expert in correctional health issues, has concluded that "[r]eleasing people from incarceration is the best and safest way to prevent the spread of disease and reduce the threat to the most vulnerable incarcerated people," and that "[i]mmediate release is crucial for individuals with chronic illnesses or other preexisting conditions."¹¹³ Release is "both necessary and urgent" given that "[t]he window of opportunity is rapidly narrowing for mitigation

¹¹² Stern Decl. ¶¶10–12, 14.

¹¹³ Mishori Decl. ¶ 46.

of COVID-19.”¹¹⁴

88. Dr. Jonathan Giftos, the former Medical Director for Correctional Health Services at Riker’s Island, concluded that “the only way to really mitigate the harm of rapid spread of coronavirus in the jail system is through depopulation, releasing as many people as possible with a focus on those at highest risk of complication.”¹¹⁵

89. Other correctional medical and public health experts have also urged the release of people from incarceration given the heightened risk of transmission and infection, including a group of doctors who work in New York City’s jails, hospitals and shelters,¹¹⁶ as well as a group of more than 200 Johns Hopkins faculty in public health, bioethics, medicine, and nursing.¹¹⁷

90. The unprecedented coronavirus pandemic unquestionably requires individuals’ release, as multiple health experts have opined that no other measures would be a sufficient or appropriate response to protect public and individual health.

91. Releasing people from the jails would also reduce the burden on

¹¹⁴ *Id.*

¹¹⁵ *Recipe for disaster: The spread of corona virus among detained populations*, MSNBC (Mar. 18, 2020), <https://www.msnbc.com/all-in/watch/-recipe-for-disaster-the-spread-of-coronavirus-among-detained-populations-80947781758>.

¹¹⁶ Ex. 7.

¹¹⁷ Ex. 8.

regional hospitals and health centers.

92. This Court has jurisdiction to release the medically vulnerable subclass immediately. It further has authority to convene a three-judge panel to determine whether to issue a Prisoner Release Order once this Court concludes that social distancing is impossible unless the population at the Jail is significantly reduced.

CLASS ACTION ALLEGATIONS

93. The named Petitioners/Plaintiffs bring this action on behalf of themselves and all others similarly situated as a class action under Federal Rule of Civil Procedure 23(b)(2).

94. The class that Petitioners/Plaintiffs seek to represent is defined as all current and future persons held at the Jail during the course of the COVID-19 pandemic (“Jail Class”), including three subclasses:

- a. The “Pre-trial Subclass” is defined as “All current and future persons detained at the Oakland County Jail during the course of the COVID-19 pandemic who have not yet been convicted of the offense for which they are currently held in the Jail.”
- b. The “Post-conviction Subclass” is defined as “All current and future persons detained at the Oakland County Jail during the course of the COVID-19 pandemic who are have been sentenced to serve time in the Jail or who are otherwise in the

Jail as the result of an offense for which they have already been convicted.”

- c. The “Medically-Vulnerable Subclass” is defined as:
- “All members of the Jail Class who are also over the age of fifty, or who, regardless of age, experience an underlying medical condition that places them at particular risk of serious illness or death from COVID-19, including but not limited to
- (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.”

95. This action is brought and may properly be maintained as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure. This action satisfies the requirements of numerosity, commonality, typicality, and adequacy. Fed. R. Civ. P. 23(a).

96. On April 15, 2020, the Jail confined over 800 people, all of whom are eligible members of this class. Therefore, the class and subclass meet the numerosity requirement of Federal Rule of Civil Procedure 23(a).

97. The subclasses are also too numerous for joinder of all members to be practicable. In Michigan, pre-trial detainees constitute approximately 50% of all people in jails,¹¹⁸ so the Pre-trial and Post-conviction subclasses likely each include approximately half of the class. And demographic data regarding the health of correctional populations indicates that well over 30% of detained people suffer from at least one condition rendering them medically vulnerable.¹¹⁹ Thus, the medically vulnerable subclass likely contains hundreds of people as well.

¹¹⁸ See Michigan Joint Task Force on Jail and Pretrial Incarceration, *Report and Recommendations* 7 (Jan. 10, 2020), <https://courts.michigan.gov/News-Events/Documents/final/Jails%20Task%20Force%20Final%20Report%20and%20Recommendations.pdf>.

¹¹⁹ Peter Wagner & Emily Widra, *No need to wait for pandemics: The public health case for criminal justice reform*, Prison Policy Initiative (Mar. 6, 2020), www.prisonpolicy.org/blog/2020/03/06/pandemic/.

Health condition	Prevalence of health condition by population			
	Jails	State prisons	Federal prisons	United States
Ever tested positive for Tuberculosis	2.5%	6.0%		0.5%
Asthma	20.1%	14.9%		10.2%
Cigarette smoking	n/a	64.7%	45.2%	21.2%
HIV positive	1.3%	1.3%		0.4%
High blood pressure/hypertension	30.2%	26.3%		18.1%
Diabetes/high blood sugar	7.2%	9.0%		6.5%
Heart-related problems	10.4%	9.8%		2.9%
Pregnancy	5.0%	4.0%	3.0%	3.9%

Health conditions that make respiratory diseases like COVID-19 more dangerous are far more common in the incarcerated population than in the general U.S. population. Pregnancy data come from our report, [Prisons neglect pregnant women in their healthcare policies](#), the CDC's [2010 Pregnancy Rates Among U.S. Women](#), and data from the [2010 Census](#). Cigarette smoking data are from a 2016 study, [Cigarette smoking among inmates by race/ethnicity](#), and all other data are from the 2015 BJS report, [Medical problems of state and federal prisoners and jail inmates, 2011-12](#), which does not offer separate data for the federal and state prison populations. Cigarette smoking [may be part of the explanation](#) of the higher fatality rate in China among men, who are far more likely to smoke than women.

98. Joinder is impracticable because the class members are numerous; the class is fluid due to the inherently transitory nature of pretrial incarceration; and the class members are incarcerated and impoverished, which limits their ability to institute individual lawsuits. Certifying this class supports judicial economy.

99. Common questions of law and fact exist as to all members of the class. The named Petitioners/Plaintiffs seek common declarative and injunctive relief concerning whether Defendants' policies, practices, and procedures violate the constitutional rights of the class members. These common questions of fact and law include, but are not limited to:

- 1) Whether the conditions of confinement at the Jail since the beginning of the COVID-19 pandemic amount to constitutional violations;
- 2) What measures Defendants implemented in the Jail in response to the COVID-19 crisis;

- 3) Whether Defendants' practices during the COVID-19 pandemic exposed people confined at the Jail to a substantial risk of serious harm; and
- 4) Whether Defendants knew of and disregarded a substantial risk of serious harm to the safety and health of the class.

100. Plaintiffs' claims are typical of the class members' claims. The injuries that Petitioners/Plaintiffs have suffered due to Defendants' unconstitutional course of conduct are typical of the injuries suffered by the class. All class members seek the same declaratory and injunctive relief.

101. The Petitioners/Plaintiffs are adequate representatives of the class because their interests in the vindication of the legal claims they raise are entirely aligned with the interests of the other class members, each of whom has the same constitutional claims. There are no known conflicts of interest among members of the proposed class, and the interests of the named Petitioners/Plaintiffs do not conflict with those of the other class members.

102. Petitioners/Plaintiffs are represented by counsel with experience and success in litigating complex civil rights matters in federal court. The interests of the members of the class will be fairly and adequately protected by the named Petitioners/Plaintiffs and their attorneys.

103. Because the putative class challenges Defendants' system as

unconstitutional through declaratory and injunctive relief that would apply the same relief to every member of the class, certification under Rule 23(b)(2) is appropriate and necessary.

104. A class action is the only practicable means, by which the named Petitioners/Plaintiffs and class members can challenge the Defendants' unconstitutional actions and obtain the necessary immediate declaratory and injunctive relief sought for themselves and all other members of the class.

DEFENDANTS' FAILURE TO ADEQUATELY MITIGATE AGAINST THE SPREAD OF COVID-19 IS OBJECTIVELY UNREASONABLE AND VIOLATES THE EIGHTH AND FOURTEENTH AMENDMENT RIGHTS OF PETITIONERS/PLAINTIFFS AND CLASS MEMBERS

105. Defendants violate Plaintiffs' Eighth and Fourteenth Amendment rights by incarcerating them in conditions that fail to adequately mitigate against the spread of a potentially fatal virus in the midst of a growing pandemic and in spite of their knowledge and ability to do so.

106. All people held in the Jail, whether detained pretrial or incarcerated post-conviction, are entitled to be protected from conditions of confinement that create a substantial risk of serious harm. *See Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (correctional officer violated Eighth Amendment by consciously failing to prevent "a substantial risk of serious harm"); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) ("deliberate indifference" to serious medical needs violates the Eighth

Amendment). Corrections officials have a constitutional obligation to provide for detainees' reasonable safety and to address their serious medical needs. *See DeShaney v. Winnebago County Dept. of Soc. Services*, 489 U.S. 189, 200 (1989) (“[W]hen the State by the affirmative exercise of its power so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.”); *Youngberg v. Romeo*, 457 U.S. 307, 315–16, 324 (1982) (the state has an “unquestioned duty to provide adequate . . . medical care” for detained persons); *Wilson v. Seiter*, 501 U.S. 294, 300 (1991); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Brown v. Plata*, 563 U.S. 493, 531-32 (2011).

107. It is well established that, under the Fourteenth Amendment, pretrial detainees are entitled to at least the same level of protection as convicted detainees. *See Richko v. Wayne Cty., Mich.*, 819 F.3d 907, 915 (6th Cir. 2016); *see also City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) (“[T]he due process rights of a [pretrial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner.”). Indeed, as explained in paragraph 112, *infra*, a pre-trial detainee’s burden of proving that the conditions of their confinement are unconstitutional are lower than for convicted persons.

108. Exposure to an infectious disease like COVID-19 without adequate preventive measures is objectively unreasonable under the Fourteenth Amendment and constitutes deliberate indifference to a serious risk to health and safety, in direct violation of the Eighth Amendment. *Helling*, 509 U.S. at 33-34 (“Nor can we hold that prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease”); *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) (“[C]orrectional officials have an affirmative obligation to protect [forcibly confined] inmates from infectious disease.”); *Flanory v. Bonn*, 604 F.3d 249 (6th Cir. 2010) (recognizing that a complete denial of dental hygiene products can constitute deliberate indifference); *see also Farmer v. Brennan*, 511 U.S. 825, 833 (1994) (“[H]aving stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.”); *Johnson v. Operation Get Down, Inc.*, No. 11-15487, 2014 WL 3752481, at *5 (E.D. Mich. 2014) (finding that even a “short period” of exposures to an infectious antibiotic resistant staph infection could constitute deliberate indifference); *Lee v. Birkett*, No. 09-cv-10723, 2010 WL 1131485, at *5 (E.D. Mich. Feb.18, 2010) (holding that allegations that prisoners were forced to use common razors and be exposed to other unsanitary conditions for two months could constitute deliberate indifference).

109. Jail officials violate this affirmative obligation towards convicted

prisoners by showing “deliberate indifference” to the substantial risk of serious harm. *Wilson*, 501 U.S. at 303. With respect to an impending infectious disease like COVID-19, deliberate indifference is satisfied when corrections officials “ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year,” even when “the complaining inmate shows no serious current symptoms.” *Helling*, 509 U.S. at 33 (holding that a prisoner “*states a cause of action* . . . by alleging that [corrections officials] have, with deliberate indifference, exposed him to conditions that pose an unreasonable risk of serious damage to future health”) (emphasis added); *see also Hope v. Pelzer*, 536 U.S. 730, 738 (2002) (citing *Farmer*, 511 U.S. at 842) (court “may infer the existence of [deliberate indifference] from the fact that the risk of harm is obvious”).

110. This Court need not “await a tragic event” to find that Defendants are maintaining unconstitutional conditions of confinement in the midst of a global pandemic. *See Helling*, 509 U.S. at 33. So long as the risk of serious harm is “likely,” as it is here, the Eighth Amendment is violated even if “the complaining inmate shows no serious current symptoms,” it is “not alleged that the likely harm would occur immediately,” and “the possible infection might not affect all of those exposed.” *Id.*

111. As established above, Petitioners/Plaintiffs face a significant risk of exposure to the novel coronavirus, which poses a serious threat of severe illness or

death to all class members, and to the Medically Vulnerable subclass in particular given the subclass members' known vulnerable health conditions. Defendants are well aware of these serious risks to their health and safety, and their failure to provide constitutionally adequate conditions of confinement during this growing global pandemic constitutes deliberate indifference.

112. Defendants' deliberate indifference to the health and safety of people incarcerated in the Jail satisfies both objective and subjective standards. However, following the Supreme Court's decision in *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), the Sixth Circuit has recognized the "shift in Fourteenth Amendment deliberate indifference jurisprudence [that] calls into serious doubt whether [pretrial detainees] need even show that the individual defendant-officials were subjectively aware of [their] serious medical conditions." *Richmond v. Huq*, 885 F.3d 928, 938 n.3 (6th Cir. 2018). As alleged in detail above, the heightened risk of COVID-19 transmission in jails and other carceral facilities have been widely reported, and the need for risk mitigation—including testing, physical distancing, and sanitation—has been well established locally and nationwide. Yet the Jail has failed to implement the types of changes required to its conditions to adequately protect against COVID-19 transmission and infection within its walls.

CLAIMS FOR RELIEF

COUNT I: Declaratory and Injunctive Relief for Violation of the Eighth Amendment

(42 U.S.C. § 1983)

Jail Class and Post-conviction Subclass versus All Defendants

113. Petitioners/Plaintiffs incorporate by reference each allegation contained in the preceding paragraphs as if set forth fully herein.

114. Under the Eighth Amendment, as applicable to States and their political subdivisions through the Fourteenth Amendment, post-convicted persons in carceral custody have a right to be free from cruel and unusual punishment. As part of the right, the government must provide incarcerated persons with reasonable safety and address serious medical needs that arise in jail. *See, e.g., Estelle*, 429 U.S. at 104; *DeShaney*, 489 U.S. at 200.

115. As part of this right, the government must provide incarcerated persons with reasonable safety and address serious medical needs that arise in jail. Deliberate indifference to the serious risk COVID-19 poses to members of the Jail Class, and particularly members of the Medically-Vulnerable Subclass, violates this right.

116. Plaintiffs, and the class they represent, suffer a substantial risk of serious harm to their health and safety due to the presence of, and spread of, COVID-19.

117. Defendants know of and are failing to abate the serious risks that COVID-19 poses to Plaintiffs, including severe illness, permanent physical damage, and death. These risks are well-established and obvious to Defendants.

118. Defendants are subjecting Petitioners/Plaintiffs to conditions of confinement that increase their risk of contracting COVID-19, for which there is no known vaccine, treatment, or care. Due to the conditions at the Jail, Petitioners/Plaintiffs are unable to take steps to protect themselves—such as social distancing, accessing medical attention or testing, or washing their hands regularly—and Defendants have failed to provide adequate protections or mitigation measures. Defendants act with deliberate indifference towards Petitioners/Plaintiffs by failing to adequately safeguard their health and safety in the midst of a potential outbreak of a contagious, infectious disease.

119. As a result of Defendants' unconstitutional actions, Petitioners/Plaintiffs are suffering irreparable injury.

120. Accordingly, Defendants, as supervisors, direct participants, and policy makers for Oakland County, have violated and are violating the rights of the Post-trial Subclasses under the Eighth Amendment.

COUNT II: Declaratory and Injunctive Relief for Violation of the Fourteenth Amendment (42 U.S.C. § 1983))
Pretrial Subclass versus All Defendants

121. Petitioners/Plaintiffs incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

122. 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) (the state has an “unquestioned duty to provide adequate . . . medical care” for detained persons); *see also City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) (“[T]he due process rights of a [pretrial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner.”)

123. Due process claims brought by pretrial detainees under the Fourteenth Amendment are evaluated under an objective standard. *See Richmond*, 885 F.3d at 938 n.3; *Castro v. Cty. of Los Angeles*, 833 F.3d 1060, 1070 (9th Cir. 2016) (en banc); *Darnell v. Pineiro*, 849 F.3d 17, 34–35 (2d Cir. 2017); *Miranda v. Cty. of Lake*, 900 F.3d 335, 352 (7th Cir. 2018). Members of the Pre-Trial subclass are not required to show that Defendants are subjectively aware of a substantial risk of serious harm due to COVID-19, although if such a showing is required that standard is met under the circumstances presented here.

124. The Jail has neither the capacity nor the ability to comply with public health guidelines to prevent an outbreak of COVID-19 and cannot provide for the safety of the Jail Class. Defendants’ actions and inactions result in the confinement of members of the Jail class in a facility where they do not have the capacity to test for, treat, or prevent COVID-19 outbreaks, which violates Plaintiffs’ rights to treatment and adequate medical care.

125. Defendants violate Petitioners/Plaintiffs’ due process rights by failing

to adequately safeguard their health and safety in the midst of a potential outbreak of a contagious, infectious disease. Petitioners/Plaintiffs face a serious risk of intense pain, illness, lasting bodily damage, and ultimately, death in the Jail due to the Defendants' insufficient measures to prevent the spread of infection.

126. Accordingly, Defendants, as supervisors, direct participants, and policy makers for Oakland County, have violated and are violating the rights of the Pre-trial Subclass under the Fourteenth Amendment.

Count III: Petition for Writ of Habeas Corpus Pursuant to 28 U.S.C. § 2241
Medically-Vulnerable Subclass versus all Defendants

127. Petitioners/Plaintiffs repeat and re-allege paragraphs 1 through 113 as if fully set forth in this Count.

128. Because the Medically Vulnerable Plaintiffs/Petitioners and subclass seek release in light of the immediate and urgent risks to their health and lives, there is no other available remedy that could protect their rights.

129. Respondents/Defendants are holding Petitioners/Plaintiffs in custody in violation of the Due Process Clause of the Eighth and/or Fourteenth Amendment to the Constitution of the United States. Both amendments forbid exposing Petitioners/Plaintiffs to a severe risk of death, pain, or permanent severe injury, and at this time, with respect to the Medically-Vulnerable Subclass, no options available to Respondents/Defendants will adequately mitigate that risk other than release from

custody.

130. Section 2241(c)(3) allows this court to order the release of people like Plaintiffs who are held “in violation of the Constitution.” 28 U.S.C. 2241(c)(3); *Preiser v. Rodriguez*, 411 U.S. 475, 484 (1973) (“It is clear, not only from the language of §§ 2241(c)(3) and 2254(a), but also from the common-law history of the writ, that the essence of habeas corpus is an attack by a person in custody upon the legality of that custody, and that the traditional function of the writ is to secure release from illegal custody.”). Such relief is appropriate where, as here, there are no set of conditions under which an individual can be constitutionally detained, and the petitioner is thus “challenging the fact, not conditions, of her confinement.”¹²⁰

COUNT IV: Declaratory and Injunctive Relief for Violation of the Fourteenth Amendment (42 U.S.C. § 1983))
Medically Vulnerable Subclass versus All Defendants

131. Petitioners/Plaintiffs repeat and re-allege paragraphs 1 through 113 as if fully set forth in this Count.

132. The Medically Vulnerable Plaintiffs/Petitioners and subclass seek release in light of the immediate and urgent risks to their health and lives. There is no other available remedy that could protect their rights.

¹²⁰ Ex. 15, Order at 8, *Malam v. Adducci*, No. 20 cv-10829 (E.D. Mich. Apr. 6, 2020), DE 23.

133. Respondents/Defendants are holding Petitioners/Plaintiffs in custody in violation of the Due Process Clause of the Eighth and/or Fourteenth Amendment to the Constitution of the United States. Both amendments forbid exposing Petitioners/Plaintiffs to a severe risk of death, pain, or permanent severe injury. At this time, with respect to the Medically Vulnerable Subclass, no options are available to Respondents/Defendants that will adequately mitigate that risk other than removing the Petitioners/Plaintiffs from custody at the Jail.

134. Accordingly, Petitioners/Plaintiffs are entitled to be transferred out of the Jail to a facility that does not expose them to an unconstitutional risk of substantial harm, including a transfer to home confinement.

PRAYER FOR RELIEF

WHEREFORE, Petitioners/Plaintiffs and the Class Members respectfully request that the Court:

- A. Certify the proposed class and subclasses;
- B. Enter a declaratory judgment that Defendants are violating Named Plaintiffs' and Class Members' constitutional rights by failing to adequately safeguard their health and safety in the midst of a potential outbreak of a contagious, infectious disease;
- C. Enter a temporary restraining order, preliminary injunction, and permanent injunction, and/or writ of habeas corpus requiring Defendants to immediately

release all Medically Vulnerable Petitioners/Plaintiffs and Subclass Members or transferring them to home confinement;

D. Enter a temporary restraining order, preliminary injunction, and permanent injunction requiring, during the COVID-19 pandemic, for Defendants to:

- a. Frequently communicate to all incarcerated people information about COVID-19, measures taken to reduce the risk of transmission, and any changes in policies or practices;
- b. Provide adequate spacing of six feet or more between incarcerated people so that social distancing can be accomplished in accordance with CDC guidelines;
- c. Ensure that each incarcerated person receives, free of charge, an individual supply of hand soap and paper towels sufficient to allow frequent hand washing and drying each day; an adequate supply of clean implements for cleaning such as sponges and brushes and disinfectant hand wipes or disinfectant products effective against the virus that causes COVID-19 for daily cleanings;
- d. Ensure that all incarcerated people have access to hand sanitizer containing at least 60% alcohol;
- e. Provide access to daily showers and daily access to clean laundry, including clean personal towels and washrags after each shower;

- f. Require that all Jail staff wear personal protective equipment, including CDC-recommended surgical masks, when interacting with any person or when touching surfaces in cells or common areas;
- g. Require that all Jail staff wash their hands, apply hand sanitizer containing at least 60% alcohol, or change their gloves both before and after interacting with any person or touching surfaces in cells or common areas;
- h. Take each incarcerated person's temperature daily (with a functioning and properly operated and sanitized thermometer) to identify potential COVID-19 infections;
- i. Assess (through questioning) each incarcerated person daily to identify potential COVID-19 infections;
- j. Conduct immediate testing for anyone displaying known symptoms of COVID-19;
- k. Ensure that individuals identified as having COVID-19 or having been exposed to COVID-19 receive adequate medical care and are properly quarantined in a non-punitive setting, with continued access to showers, recreation, mental health services, reading materials, phone and video visitation with loved ones, communications with counsel, and personal property;

- l. Respond to all emergency (as defined by the medical community) requests for medical attention within an hour;
 - m. Provide sufficient disinfecting supplies, free of charge, so incarcerated people can clean high-touch areas or items (including, but not limited to, phones and headphones) between each use;
 - n. Waive all medical co-pays for those experiencing COVID-19-related symptoms;
 - o. Waive all charges for medical grievances during this health crisis;
 - p. Cease and desist relocating or threatening to relocate incarcerated people into infected areas of the jail as punishment or sanction for any kind of conduct.
- E. If immediate release is not granted on the basis of this Petition alone, expedite review of the Petition, including oral argument, via telephonic or videoconference if necessary;
- F. Enter an order and judgment granting reasonable attorneys' fees and costs pursuant to 42 U.S.C. § 1988;
- G. Order such other and further relief as this Court deems just, proper, and equitable.

Respectfully submitted,

/s/ Krithika Santhanam

Krithika Santhanam (DC Bar No. 1632807)*
Thomas B. Harvey (MBE #61734MO)*
Advancement Project National Office
1220 L Street, N.W., Suite 850
Washington, DC 20005
Tel: (202) 728-9557
Ksanthanam@advancementproject.org
Tharvey@advancementproject.org

/s/ Philip Mayor

Philip Mayor (P81691)
Daniel S. Korobkin (P72842)
American Civil Liberties Union
Fund of Michigan
2966 Woodward Ave.
Detroit, MI 48201
(313) 578-6803
pmayor@aclumich.org
dkorobkin@aclumich.org

/s/ Alexandria Twinem

Alexandria Twinem (D.C. Bar No. 1644851)*
Civil Rights Corps
1601 Connecticut Ave NW, Suite 800
Washington, DC 20009
Tel: 202-894-6126 Fax: 202-609-8030
alexandria@civilrightscorps.org

/s/ Cary S. McGehee

Cary S. McGehee (P42318)
Kevin M. Carlson (P67704)
Pitt, McGehee, Palmer,
Bonanni & Rivers, PC
117 W. Fourth Street, Suite 200
Royal Oak, MI 48067
248-398-9800
cmcgehee@pittlawpc.com
kcarlson@pittlawpc.com

/s/ Allison L. Kriger

Allison L. Kriger (P76364)
LaRene & Kriger, PLC
645 Griswold, Suite 1717
Detroit, MI 48226
(313) 967-0100
Allison.kriger@gmail.com

Attorneys for Plaintiffs/Petitioners

*Applications for admission forthcoming

Dated: April 17, 2020

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

Richard Briggs, Jamaal Cameron, David Kucharski, Raj Lee, Michael Cameron, Matthew Saunders

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

(c) Attorneys (Firm Name, Address, and Telephone Number)
Cary S. McGehee (P42318)
Pitt McGehee Palmer Bonanni & Rivers
117 W. 4th Street, Suite 200
Royal Oak, MI 48067 (248) 398-9800

DEFENDANTS

Oakland County Michigan, Michael Bouchard, Curtis D. Childs

County of Residence of First Listed Defendant Oakland
(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 ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant ☐ 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)

- | | 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)

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 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	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	☐ 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	☐ 422 Appeal 28 USC 158 ☐ 423 Withdrawal 28 USC 157 PROPERTY RIGHTS ☐ 820 Copyrights ☐ 830 Patent ☐ 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	☐ 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 ☐ 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
REAL PROPERTY ☐ 210 Land Condemnation ☐ 220 Foreclosure ☐ 230 Rent Lease & Ejectment ☐ 240 Torts to Land ☐ 245 Tort Product Liability ☐ 290 All Other Real Property	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			

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

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity): 42 U.S.C. § 1983

Brief description of cause: 8th & 14th Amendment violations

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 April 17, 2020 SIGNATURE OF ATTORNEY OF RECORD /s/ Cary S. McGehee

FOR OFFICE USE ONLY

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

INDEX OF EXHIBITS

- Exhibit 1: Declaration of Dr. Marc Stern
- Exhibit 2: Declaration of Dr. Jaime Meyer
- Exhibit 3: Declaration of Elizabeth Y. Chiao
- Exhibit 4: Declaration of Dr. Jonathan Golob
- Exhibit 5: Declaration of Dr. Carlos Franco Parades
- Exhibit 6: CDC Interim Guidance on Management of Coronavirus Disease 2019
- Exhibit 7: Letter from NYC Council Member Brad Lander
- Exhibit 8: Letter from John Hopkins Faculty to Governor Hogan
- Exhibit 9: Declaration of Dr. Monat Mishori
- Exhibit 10: Declaration of Robert B. Greifinger
- Exhibit 11: Michigan Executive Order 2020-29
- Exhibit 12: Letter from ACLU of Michigan to Chief Judges, March 31, 2020
- Exhibit 13: Letter from ACLU of Michigan to Sheriffs, March 31, 2020
- Exhibit 14: Declaration of Dr. Adam Luring
- Exhibit 15: Order, *Malam v. Adducci*, No. 20-cv-10829 (E.D. Mich. April 6, 2020)

Exhibit 1

DECLARATION OF DR. MARC STERN, MD MPH

On this 14th day of April, 2020, I hereby declare:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. On a regular basis, I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections. In terms of educational background, I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University in 1992. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

2. My prior experience includes working with the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails. Through 2013, I taught the National Commission on Correctional Health Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train

jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course. I currently also serve as the COVID-19 expert resource to the National Sheriffs Association and the Washington Association of Sheriffs and Police Chiefs.

3. In the past four years alone, I have been qualified as an expert in several jurisdictions on correctional health care systems and conditions of confinement. Attached as Exhibit A is a copy of my curriculum vitae.

4. I am not receiving payment in exchange for providing this affidavit to counsel for the Plaintiffs regarding appropriate correctional healthcare measures during the COVID-19 pandemic. In light of the emergency conditions occurring in jails and prisons across the country, I am providing my services *pro bono*.

5. I am familiar with the virus from a clinical perspective, including its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through correctional facilities.

6. In the context of a pandemic like the one we currently face, public health and public safety interests are closely intertwined. When and if correctional staffing challenges arise due to the need for staff to quarantine, seek treatment, or care for dependents, managing internal safety in carceral settings becomes

even more challenging. Understaffing in the correctional setting is dangerous for staff as well as incarcerated people, and the stress and fear of the current crisis only serve to increase those risks.

7. Jails and prisons are congregate environments, i.e. places where people live, eat, shower, and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch, as does COVID-19 – are more likely to spread. The spread of COVID-19 in similar environments such as nursing homes and cruise ships, and now correctional facilities themselves, has already been demonstrated.

8. The CDC and other public health authorities recommend a number of preventive steps to prevent or decrease the spread of COVID-19. It can be difficult if not impossible to execute all these recommendations or execute them effectively in jails and prisons, placing people at risk.

9. Although it is important for jails to comply with the CDC recommendations, it is equally important to understand that compliance with these standards alone is not enough to create a carceral setting that fully protects the health and safety of the people detained there. First of all, although the CDC guidelines are based on science, as a federal institution, CDC would avoid issuing recommendations, such as downsizing, that can be seen as imposing requirements on local governments around the country, even when the science would support

such recommendations. Second, and relatedly, the CDC guidelines incorporate a “harm reduction” approach, a common practice in public health guidance. The harm reduction approach recognizes that though there is an appropriate and safe way to address a public health problem, people do not always do things in that way, and so provides guidance on how to reduce risk of harm even when not following the appropriate practices. For example, the CDC guidance, like public health guidance everywhere, states that social distancing should permit six feet or more of social distancing between sleeping quarters, but also states that such distancing should be provided “if space allows.” This does **not** mean that it is safe to have less than six feet of social distance in a jail, and in fact a carceral setting that does not allow for such social distancing is not a safe one and is likely to facilitate the spread of COVID-19.

10. For this reason, it is also important to reduce the number of persons incarcerated. I recognize that in most institutions, this number cannot be reduced to zero. However, the lower the number, the lower the risk. In other words, reducing the population to, say, a number that allows single occupancy in all rooms is better than maintaining a higher population number, but will still not achieve the level of risk that would exist if the population were released.

11. Downsizing jail populations serves two critical public health aims: (1) targeting residents who are at elevated risk of suffering from severe symptoms

of COVID-19 (“medically at-risk”); and (2) allowing those who remain incarcerated to maintain social distancing and avoid other risks associated with forced communal living. Because medically at-risk populations are at the highest risk of severe complications from COVID-19, and because when they develop severe complications they will be transported to community hospitals—thereby using scarce community resources (ER beds, general hospital beds, ICU beds)—avoiding disease in this population is a critical contribution to public health overall. Because the staff who work at the jail share risk with the communal residents, reducing spread of infection in the jail significantly reduces the chances of a staff member infecting his or her family or community.

12. Downsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to “flatten the curve” overall—both within the jail setting and without.

13. Thus, taking immediate and concerted efforts to implement preventive steps, as well as reducing the population to the lowest number possible prioritizing those who are elderly or have underlying medical conditions defined by the CDC, will increase public safety via reducing public health risk.

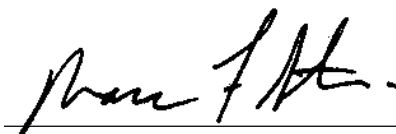
14. For the first time in history, large scale decisions about incarceration need to be made on the basis of public safety, not only considering criminal justice-related factors, but also public health-related factors.

15. I have reviewed the declarations of Jamaal Cameron and Richard Briggs. If accurate, they highlight a number of conditions or practices that are inconsistent with current public health recommendations: crowded conditions which do not allow safe distancing; unsafe practices for isolating residents with suspected COVID-19; inadequate disinfection of frequently touched common surfaces, inadequate provision of supplies for disinfecting surfaces; inadequate provision of hand soap, and inadequate access to episodic care (barriers to requesting care and insufficient evaluation when care is accessed).

16. Thoughtful downsizing that takes into account public safety, based not only criminal justice-related factors, but also public health-related factors, should be implemented in tandem with aggressive prevention measures that are based on national recommendations, modified, as necessary by public health and medical experts to adapt to the unique combination of physical structure and layout, operations, policies, logistics, inmate characteristics, and staffing factors of the jail.

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

Executed on April 14, 2020.

A handwritten signature in black ink, appearing to read "Marc Stern", is written over a horizontal line.

Marc Stern, MD MPH

EXHIBIT A
CV of Dr. Marc Stern

MARC F. STERN, M.D., M.P.H., F.A.C.P.

April, 2020

marcstern@live.com

+1 (360) 701-6520

SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT

2009 – PRESENT

Consultant in the design, management, and operation of health services in a correctional setting to assist in evaluating, monitoring, or providing evidence-based, cost-effective care consistent with constitutional mandates of quality.

Current activities include:

- COVID-19 Medical Advisor, National Sheriffs Association (2020 -)
- Advisor to various jails in Washington State on patient safety, health systems, and related health care and custody staff activities and operations, and RFP and contract generation (2014 -)
- Consultant to the US Department of Justice, Civil Rights Division, Special Litigation Section. Providing investigative support and expert medical services pursuant to complaints regarding care delivered in any US jail, prison, or detention facility. (2010 -) (no current open cases)
- Physician prescriber/trainer for administration of naloxone by law enforcement officers for the Olympia, Tumwater, Lacey, Yelm, and Evergreen College Police Departments (2017 -)
- Consultant to the Civil Rights Enforcement Section, Office of the Attorney General of California, under SB 29, to review the healthcare-related conditions of confinement of detainees confined by Immigration and Customs Enforcement in California facilities (2017 -)
- Rule 706 Expert to the Court, US District Court for the District of Arizona, in the matter of Parsons v. Ryan (2018 -)

Previous activities include:

- Consultant to Human Rights Watch to evaluate medical care of immigrants in Homeland Security detention (2016 - 2018)
- Consultant to Broward County Sheriff to help develop and evaluate responses to a request for proposals (2017 - 2018)
- Member of monitoring team (medical expert) pursuant to Consent Agreement between US Department of Justice and Miami-Dade County (Unites States of America v Miami-Dade County, *et al.*) regarding, *entre outre*, unconstitutional medical care. (2013 - 2016)
- Jointly appointed Consultant to the parties in Flynn v Walker (formerly Flynn v Doyle), a class action lawsuit before the US Federal District Court (Eastern District of Wisconsin) regarding Eighth Amendment violations of the health care provided to women at the Taycheedah Correctional Institute. Responsible for monitoring compliance with the medical component of the settlement. (2010 - 2015)
- Consultant on “Drug-related Death after Prison Release,” a research grant continuing work with Dr. Ingrid Binswanger, University of Colorado, Denver, examining the causes of, and methods of reducing deaths after release from prison to the community. National Institutes of Health Grant R21 DA031041-01. (2011 - 2016)
- Consultant to the US Department of Homeland Security, Office for Civil Rights and Civil Liberties. Providing investigative support and expert medical services pursuant to complaints regarding care received by immigration detainees in the custody of U.S. Immigration and Customs Enforcement. (2009 - 2014)
- Special Master for the US Federal District Court (District of Idaho) in Balla v Idaho State Board of Correction, *et al.*, a class action lawsuit alleging Eighth Amendment violations in provision of health care at the Idaho State Correctional Institution. (2011 - 2012)
- Facilitator/Consultant to the US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, providing assistance and input for the development of the first National Survey of Prisoner Health. (2010-2011)
- Project lead and primary author of National Institute of Corrections’ project entitled “Correctional Health Care Executive Curriculum Development,” in collaboration with National Commission on Correctional Health Care. NIC commissioned this curriculum for its use to train executive leaders from jails and prisons across the nation to better manage the health care missions of their facilities. Cooperative Agreement 11AD11GK18, US Department of Justice, National Institute of Corrections. (2011 - 2015)

- Co-teacher, with Jaye Anno, Ph.D., for the National Commission on Correctional Health Care, of the Commission's standing course, *An In-Depth Look at NCCHC's 2008 Standards for Health Services in Prisons and Jails* taught at its national meetings. (2010 - 2013)
- Contributor to 2014 Editions of Standards for Health Services in Jails and Standards for Health Services in Prisons, National Commission on Correctional Health Care. (2013)
- Consultant to the California Department of Corrections and Rehabilitation court-appointed Receiver for medical operations. Projects included:
 - Assessing the Receiver's progress in completing its goal of bringing medical care delivered in the Department to a constitutionally mandated level. (2009)
 - Providing physician leadership to the Telemedicine Program Manager tasked with improving and expanding the statewide use of telemedicine. (2009)
- Conceived, co-designed, led, and instructed in American College of Correctional Physicians and National Commission on Correctional Health Care's Medical Directors Boot Camp (now called Leadership Institute), a national training program for new (Track "101") and more experienced (Track "201") prison and jail medical directors. (2009 - 2012)
- Participated as a member of a nine-person Delphi expert consensus panel convened by Rand Corporation to create a set of correctional health care quality standards. (2009)
- Convened a coalition of jails, Federally Qualified Health Centers, and community mental health centers in ten counties in Washington State to apply for a federal grant to create an electronic network among the participants that will share prescription information for the correctional population as they move among these three venues. (2009 - 2010)
- Participated as a clinical expert in comprehensive assessment of Michigan Department of Corrections as part of a team from the National Commission on Correctional Health Care. (2007)
- Provided consultation to Correctional Medical Services, Inc., St. Louis (now Corizon), on issues related to development of an electronic health record. (2001)
- Reviewed cases of possible professional misconduct for the Office of Professional Medical Conduct of the New York State Department of Health. (1999 - 2001)
- Advised Deputy Commissioner, Indiana State Board of Health, on developing plan to reduce morbidity from chronic diseases using available databases. (1992)
- Provided consultation to Division of General Medicine, University of Nevada at Reno, to help develop a new clinical practice site combining a faculty practice and a supervised resident clinic. (1991)

OLYMPIA BUPRENORPHINE CLINIC, OLYMPIA, WASHINGTON**2019 - PRESENT**

Volunteer practitioner at a low-barrier clinic to providing Medication Assisted Treatment (buprenorphine) to opioid dependent individuals wishing to begin treatment, until they can transition to a long-term treatment provider

OLYMPIA FREE CLINIC, OLYMPIA, WASHINGTON**2017 - PRESENT**

Volunteer practitioner providing episodic care at a neighborhood clinic which provides free care to individuals without health insurance until they can find a permanent medical home

OLYMPIA UNION GOSPEL MISSION CLINIC, OLYMPIA, WASHINGTON**2009 - 2014**

Volunteer practitioner providing primary care at a neighborhood clinic which provides free care to individuals without health insurance until they can find a permanent medical home; my own patient panel within the practice focuses on individuals recently released jail and prison.

WASHINGTON STATE DEPARTMENT OF CORRECTIONS**2002 - 2008**

Assistant Secretary for Health Services/Health Services Director, 2005 - 2008

Associate Deputy Secretary for Health Care, 2002 - 2005

Responsible for the medical, mental health, chemical dependency (transiently), and dental care of 15,000 offenders in total confinement. Oversaw an annual operating budget of \$110 million and 700 health care staff.

- As the first incumbent ever in this position, ushered the health services division from an operation of 12 staff in headquarters, providing only consultative services to the Department, to an operation with direct authority and

responsibility for all departmental health care staff and budget. As part of new organizational structure, created and filled statewide positions of Directors of Nursing, Medicine, Dental, Behavioral Health, Mental Health, Psychiatry, Pharmacy, Operations, and Utilization Management.

- Significantly changed the culture of the practice of correctional health care and the morale of staff by a variety of structural and functional changes, including: ensuring that high ethical standards and excellence in clinical practice were of primordial importance during hiring of professional and supervisory staff; supporting disciplining or career counseling of existing staff where appropriate; implementing an organizational structure such that patient care decisions were under the final direct authority of a clinician and were designed to ensure that patient needs were met, while respecting and operating within the confines of a custodial system.
- Improved quality of care by centralizing and standardizing health care operations, including: authoring a new Offender Health Plan defining patient benefits based on the Eighth Amendment, case law, and evidence-based medicine; implementing a novel system of utilization management in medical, dental, and mental health, using the medical staffs as real-time peer reviewers; developing a pharmacy procedures manual and creating a Pharmacy and Therapeutics Committee; achieving initial American Correctional Association accreditation for 13 facilities (all with almost perfect scores on first audit); migrating the eight individual pharmacy databases to a single central database.
- Blunted the growth in health care spending without compromising quality of care by a number of interventions, including: better coordination and centralization of contracting with external vendors, including new statewide contracts for hospitalization, laboratory, drug purchasing, radiology, physician recruitment, and agency nursing; implementing a statewide formulary; issuing quarterly operational reports at the state and facility levels.
- Piloted the following projects: direct issuance of over-the-counter medications on demand through inmates stores (commissary), obviating the need for a practitioner visit and prescription; computerized practitioner order entry (CPOE); pill splitting; ER telemedicine.
- Oversaw the health services team that participated variously in pre-design, design, or build phases of five capital projects to build complete new health units.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES

2001 – 2002

Regional Medical Director, Northeast Region, 2001 – 2002

Responsible for clinical oversight of medical services for 14,000 offenders in 14 prisons, including one (already) under court monitoring.

- Oversaw contract with vendor to manage 60-bed regional infirmary and hospice.
- Coordinated activities among the Regional Medical Unit outpatient clinic, the Albany Medical College, and the 13 feeder prisons to provide most of the specialty care for the region.
- Worked with contracting specialists and Emergency Departments to improve access and decrease medical out-trips by increasing the proportion of scheduled and emergency services provided by telemedicine.
- Provided training, advice, and counseling to practitioners and facility health administrators in the region to improve the quality of care delivered.

CORRECTIONAL MEDICAL SERVICES, INC. (now CORIZON)

2000 – 2001

Regional Medical Director, New York Region, 2000 – 2001

Responsible for clinical management of managed care contract with New York State Department of Correctional Services to provide utilization management services for the northeast and northern regions of New York State and supervision of the 60-bed regional infirmary and hospice.

- Migrated the utilization approval function from one of an anonymous rule-based “black box” to a collaborative evidence-based decision making process between the vendor and front-line clinicians.

MERCY INTERNAL MEDICINE, ALBANY, NEW YORK

1999 – 2000

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

Provided direct primary care to a panel of community patients during a period of staff shortage.

ALBANY COUNTY CORRECTIONAL FACILITY, ALBANY, NEW YORK**1998 – 1999**Acting Facility Medical Director, 1998 – 1999

Directed the medical staff of an 800 bed jail and provided direct patient care following the sudden loss of the Medical Director, pending hiring of a permanent replacement. Coordinated care of jail patients in local hospitals. Provided consultation to the Superintendent on improvements to operation and staffing of medical unit and need for privatization.

VETERANS ADMINISTRATION MEDICAL CENTER, ALBANY, NY**1992 – 1998**Assistant Chief, Medical Service, 1995 – 1998Chief, Section of General Internal Medicine and Emergency Services, 1992 – 1998

Responsible for operation of the general internal medicine clinics and the Emergency Department.

- Designed and implemented an organizational and physical plant makeover of the general medicine ambulatory care clinic from an episodic-care driven model with practitioners functioning independently supported by minimal nursing involvement, to a continuity-of-care model with integrated physician/mid-level practitioner/registered nurse/licensed practice nurse/practice manager teams.
- Led the design and opening of a new Emergency Department.
- As the VA Section Chief of Albany Medical College's Division of General Internal Medicine, coordinated academic activities of the Division at the VA, including oversight of, and direct teaching in, ambulatory care and inpatient internal medicine rotations for medical students, residents, and fellows. Incorporated medical residents as part of the general internal medicine clinics. Awarded \$786,000 Veterans Administration grant ("PRIME I") over four years for development and operation of educational programs for medicine residents and students in allied health professions (management, pharmacy, social work, physician extenders) wishing to study primary care delivery.

ERIE COUNTY HEALTH DEPARTMENT, BUFFALO, NY**1988 – 1990**Director of Sexually Transmitted Diseases (STD) Services, 1989 – 1990Staff Physician, STD Clinic, 1988 – 1989Staff Physician, Lackawanna Community Health Center, 1988 – 1990

Provided leadership and patient care services in the evaluation and treatment of STDs. Successfully reorganized the county's STD services which were suffering from mismanagement and were under public scrutiny. Provided direct patient care services in primary care clinic for underserved neighborhood.

UNION OCCUPATIONAL HEALTH CENTER, BUFFALO, NY**1988 – 1990**Staff Physician, 1988 – 1990

Provided direct patient care for the evaluation of occupationally-related health disorders.

VETERANS ADMINISTRATION MEDICAL CENTER, BUFFALO, NY**1985 – 1990**Chief Outpatient Medical Section and Primary Care Clinic, 1986 – 1988VA Section Head, Division of General Internal Medicine, University of Buffalo, 1986 – 1988

- Developed and implemented a major restructuring of the general medicine ambulatory care clinic to reduce fragmentation of care by introduction of a continuity-of-care model with a physician/nurse team approach.

Medical Director, Anticoagulation Clinic 1986 – 1990Staff Physician, Emergency Department, 1985 – 1986**FACULTY APPOINTMENTS**

2020 – present	Faculty Associate, Center for Human Rights, University of Washington
2007 – present	Affiliate Assistant Professor, Department of Health Services, School of Public Health, University of Washington
1999 – present	Clinical Professor, Fellowship in Applied Public Health (previously Volunteer Faculty, Preventive Medicine Residency), University at Albany School of Public Health
1996 – 2002	Volunteer Faculty, Office of the Dean of Students, University at Albany

1992 – 2002	Associate Clinical/Associate/Assistant Professor of Medicine, Albany Medical College
1993 – 1997	Clinical Associate Faculty, Graduate Program in Nursing, Sage Graduate School
1990 – 1992	Instructor of Medicine, Indiana University
1985 – 1990	Clinical Assistant Professor of Medicine, University of Buffalo
1982 – 1985	Clinical Assistant Instructor of Medicine, University of Buffalo

OTHER PROFESSIONAL ACTIVITIES

2016 – present	Chair, Education Committee, Academic Consortium on Criminal Justice Health
2016 – present	Washington State Institutional Review Board (“Prisoner Advocate” member)
2016 – 2017	Mortality Reduction Workgroup, American Jail Association
2013 – present	Conference Planning Committee – Medical/Mental Health Track, American Jail Association
2013 – 2016	“Health in Prisons” course, Bloomberg School of Public Health, Johns Hopkins University/International Committee of the Red Cross
2013 – present	Institutional Review Board, University of Washington (“Prisoner Advocate” member),
2011 – 2012	Education Committee, National Commission on Correctional Health Care
2007 – present	National Advisory Committee, COCHS (Community–Oriented Correctional Health Services)
2004 – 2006	Fellow’s Advisory Committee, University of Washington Robert Wood Johnson Clinical Scholar Program
2004	External Expert Panel to the Surgeon General on the “Call to Action on Correctional Health Care”
2003 – present	Faculty Instructor, Critical Appraisal of the Literature Course, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington
2001 – present	Chair/Co-Chair, Education Committee, American College of Correctional Physicians
1999 – present	Critical Appraisal of the Literature Course, Preventive Medicine Residency Program, New York State Department of Health/University at Albany School of Public Health
1999	Co–Chairperson, Education Subcommittee, Workshop Submission Review Committee, Annual Meeting, Society of General Internal Medicine
1997 – 1998	Northeast US Representative, National Association of VA Ambulatory Managers
1996 – 2002	Faculty Mentor, Journal Club, Internal Medicine Residency Program, Albany Medical College
1996 – 2002	Faculty Advisor and Medical Control, 5 Quad Volunteer Ambulance Service, University at Albany
1995 – 1998	Preceptor, MBA Internship, Union College
1995	Quality Assurance/Patient Satisfaction Subcommittee, VA National Curriculum Development Committee for Implementation of Primary Care Practices, Veterans Administration
1994 – 1998	Residency Advisory Committee, Preventive Medicine Residency, New York State Department of Health/School of Public Health, University at Albany
1993	Chairperson, Dean’s Task Force on Primary Care, Albany Medical College
1993	Task Group to develop curriculum for Comprehensive Care Case Study Course for Years 1 through 4, Albany Medical College
1988 – 1989	Teaching Effectiveness Program for New Housestaff, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1990	Human Studies Review Committee, School of Allied Health Professions, University of Buffalo
1987 – 1989	Chairman, Subcommittee on Hospital Management Issues and Member, Subcommittee on Teaching of Ad Hoc Committee to Plan Incoming Residents Training Week, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1988	Dean’s Ad Hoc Committee to Reorganize “Introduction to Clinical Medicine” Course
1987	Preceptor, Nurse Practitioner Training Program, School of Nursing, University of Buffalo
1986 – 1988	Course Coordinator, Simulation Models Section of Physical Diagnosis Course, University of Buffalo
1986 – 1988	Chairman, Service Chiefs’ Continuity of Care Task Force, Veterans Administration Medical Center, Buffalo, New York
1979 – 1980	Laboratory Teaching Assistant in Gross Anatomy, Université Libre de Bruxelles, Brussels, Belgium

1973 – 1975 Instructor and Instructor Trainer of First Aid, American National Red Cross

1972 – 1975 Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.

1972 – 1975 Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

REVIEWER/EDITOR

2019 – present Criminal Justice Review (reviewer)

2015 – present PLOS ONE (reviewer)

2015 – present Founding Editorial Board Member and Reviewer, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut

2011 – present American Journal of Public Health (reviewer)

2010 – present International Advisory Board Member and Reviewer, International Journal of Prison Health

2010 – present Langeloth Foundation (grant reviewer)

2001 – present Reviewer and Editorial Board Member (2009 – present), Journal of Correctional Health Care

2001 – 2004 Journal of General Internal Medicine (reviewer)

1996 Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine (reviewer)

1990 – 1992 Medical Care (reviewer)

EDUCATION

University at Albany, College of Arts and Sciences, Albany; B.S., 1975 (Biology)

University at Albany, School of Education, Albany; AMST (Albany Math and Science Teachers) Teacher Education Program, 1975

Université Libre de Bruxelles, Faculté de Medecine, Brussels, Belgium; Candidature en Sciences Medicales, 1980

University at Buffalo, School of Medicine, Buffalo; M.D., 1982

University at Buffalo Affiliated Hospitals, Buffalo; Residency in Internal Medicine, 1985

Regenstrief Institute of Indiana University, and Richard L. Roudebush Veterans Administration Medical Center; VA/NIH Fellowship in Primary Care Medicine and Health Services Research, 1992

Indiana University, School of Health, Physical Education, and Recreation, Bloomington; M.P.H., 1992

New York Academy of Medicine, New York; Mini-fellowship Teaching Evidence-Based Medicine, 1999

CERTIFICATION

Provisional Teaching Certification for Biology, Chemistry, Physics, Grades 7–12, New York State Department of Education (expired), 1975

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

License: Washington (#MD00041843, active); New York (#158327, inactive); Indiana (#01038490, inactive)

“X” Waiver (buprenorphine), Department of Health & Human Services, 2018

MEMBERSHIPS

2019 – present Washington Association of Sheriffs and Police Chiefs

2005 – 2016 American Correctional Association/Washington Correctional Association

2004 – 2006 American College of Correctional Physicians (Member, Board of Directors, Chair Education Committee)

2000 – present American College of Correctional Physicians

RECOGNITION

B. Jaye Anno Award for Excellence in Communication, National Commission on Correctional Health Care. 2019
 Award of Appreciation, Washington Association of Sheriffs and Police Chiefs. 2018
 Armond Start Award of Excellence, American College of Correctional Physicians. 2010
 (First) Annual Preventive Medicine Faculty Excellence Award, New York State Preventive Medicine Residency Program, University at Albany School of Public Health/New York State Department of Health. 2010
 Excellence in Education Award for excellence in clinical teaching, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington. 2004
 Special Recognition for High Quality Workshop Presentation at Annual Meeting, Society of General Internal Medicine. 1996
 Letter of Commendation, House Staff Teaching, University of Buffalo. 1986

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

It's the 21st Century – Time to Bid Farewell to “Sick Call” and “Chronic Care Clinic”. Annual Conference, National Commission on Correctional Health Care. Fort Lauderdale, Florida. 2019

HIV and Ethics – Navigating Medical Ethical Dilemmas in Corrections. Keynote Speech, 14th Annual HIV Care in the Correctional Setting. AIDS Education and Training Program (AETC) Mountain West, Olympia, Washington. 2019

Honing Nursing Skills to Keep Patients Safe in Jail. Orange County Jail Special Training Session (including San Bernardino and San Diego Jail Staffs), Theo Lacy Jail, Orange, California. 2019

What Would You Do? Navigating Medical Ethical Dilemmas. Leadership Training Academy, National Commission on Correctional Health Care. San Diego, California. 2019

Preventing Jail Deaths. Jail Death Review and Investigations: Best Practices Training Program, American Jail Association, Arlington, Virginia. 2018

How to Investigate Jail Deaths. Jail Death Review and Investigations: Best Practices Training Program, American Jail Association, Arlington, Virginia. 2018

Executive Manager Program in Correctional Health. 4-day training for custody/health care teams from jails and prisons on designing safe and efficient health care systems. National Institute for Corrections Training Facility, Aurora, Colorado, and other venues in Washington State. Periodically. 2014 – present

Medical Ethics in Corrections. Criminal Justice 441 – Professionalism and Ethical Issues in Criminal Justice. University of Washington, Tacoma. Recurring seminar. 2012 – present

Medical Aspects of Deaths in ICE Custody. Briefing for U.S. Senate staffers, Human Rights Watch. Washington, D.C. 2018

Jails' Role in Managing the Opioid Epidemic. Panelist. Washington Association of Sheriffs and Police Chiefs Annual Conference. Spokane, Washington. 2018

Contract Prisons and Contract Health Care: What Do We Know? Behind Bars: Ethics and Human Rights in U.S. Prisons Conference. Center for Bioethics – Harvard Medical School/Human Rights Program – Harvard Law School. Boston, Massachusetts. 2017

Health Care Workers in Prisons. (With Dr. J. Wesley Boyd) Behind Bars: Ethics and Human Rights in U.S. Prisons Conference. Center for Bioethics – Harvard Medical School/Human Rights Program – Harvard Law School. Boston, Massachusetts. 2017

Prisons, Jails and Medical Ethics: Rubber, Meet Road. Grand Rounds. Touro Medical College. New York, New York. 2017

Jail Medical Doesn't Have to Keep You Up at Night – National Standards, Risks, and Remedies. Washington Association of Counties. SeaTac, Washington. 2017

Prison and Jail Health Care: What do you need to know? Grand Rounds. Providence/St. Peters Medical Center. Olympia, Washington. 2017

Prison Health Leadership Conference. 2-Day workshop. International Corrections and Prisons Association/African Correctional Services Association/Namibian Corrections Service. Omaruru, Namibia. 2016; 2018

What Would YOU Do? Navigating Medical Ethical Dilemmas. Spring Conference. National Commission on Correctional Health Care. Nashville, Tennessee. 2016

Improving Patient Safety. Spring Provider Meeting. Oregon Department of Corrections. Salem, Oregon 2016

A View from the Inside: The Challenges and Opportunities Conducting Cardiovascular Research in Jails and Prisons. Workshop on Cardiovascular Diseases in the Inmate and Released Prison Population. The National Heart, Lung, and Blood Institute. Bethesda, Maryland. 2016

Why it Matters: Advocacy and Policies to Support Health Communities after Incarceration. At the Nexus of Correctional Health and Public Health: Policies and Practice session. Panelist. American Public Health Association Annual Meeting. Chicago, Illinois. 2015

Hot Topics in Correctional Health Care. Presented with Dr. Donald Kern. American Jail Association Annual Meeting. Charlotte, North Carolina. 2015

Turning Sick Call Upside Down. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

Diagnostic Maneuvers You May Have Missed in Nursing School. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

The Challenges of Hunger Strikes: What Should We Do? What Shouldn't We Do? Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

Practical and Ethical Approaches to Managing Hunger Strikes. Annual Practitioners' Conference. Washington Department of Corrections. Tacoma, Washington. 2015

Contracting for Health Services: Should I, and if so, how? American Jail Association Annual Meeting. Dallas, Texas. 2014

Hunger Strikes: What should the Society of Correctional Physician's position be? With Allen S, May J, Ritter S. American College of Correctional Physicians (Formerly Society of Correctional Physicians) Annual Meeting. Nashville, Tennessee. 2013

Addressing Conflict between Medical and Security: an Ethics Perspective. International Corrections and Prison Association Annual Meeting. Colorado Springs, Colorado. 2013

Patient Safety and 'Right Using' Nurses. Keynote address. Annual Conference. American Correctional Health Services Association. Philadelphia, Pennsylvania. 2013

Patient Safety: Overuse, underuse, and misuse...of nurses. Keynote address. Essentials of Correctional Health Care conference. Salt Lake City, Utah. 2012

The ethics of providing healthcare to prisoners-An International Perspective. Global Health Seminar Series. Department of Global Health, University of Washington, Seattle, Washington. 2012

Recovery, Not Recidivism: Strategies for Helping People Who are Incarcerated. Panelist. NAMI Annual Meeting, Seattle, Washington, 2012

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Salem, Oregon. 2011

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Spokane, Washington. 2011

Patient Safety: Raising the Bar in Correctional Health Care. With Dr. Sharen Barboza. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee. 2010

Patient Safety: Raising the Bar in Correctional Health Care. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Achieving Quality Care in a Tough Economy. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee, 2010 (Co-presented with Rick Morse and Helena Kim, PharmD.)

Involuntary Psychotropic Administration: The Harper Solution. With Dr. Bruce Gage. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Evidence Based Decision Making for Non-Clinical Correctional Administrators. American Correctional Association 139th Congress, Nashville, Tennessee. 2009

Death Penalty Debate. Panelist. Seattle University School of Law, Seattle, Washington. 2009

The Patient Handoff – From Custody to the Community. Washington Free Clinic Association, Annual Meeting, Olympia, Washington. Lacey, Washington. 2009

Balancing Patient Advocacy with Fiscal Restraint and Patient Litigation. National Commission on Correctional Health Care and American College of Correctional Physicians “Medical Directors Boot Camp,” Seattle, Washington. 2009

Staff Management. National Commission on Correctional Health Care and American College of Correctional Physicians “Medical Directors Boot Camp,” Seattle, Washington. 2009

Management Dilemmas in Corrections: Boots and Bottom Bunks. Annual Meeting, American College of Correctional Physicians, Chicago, Illinois. 2008

Public Health and Correctional Health Care. Masters Program in community-based population focused management – Populations at risk, Washington State University, Spokane, Washington. 2008

Managing the Geriatric Population. Panelist. State Medical Directors’ Meeting, American Corrections Association, Alexandria, Virginia. 2007

I Want to do my own Skin Biopsies. Annual Meeting, American College of Correctional Physicians, New Orleans, Louisiana. 2005

Corrections Quick Topics. Annual Meeting, American College of Correctional Physicians. Austin, Texas. 2003

Evidence Based Medicine in Correctional Health Care. Annual Meeting, National Commission on Correctional Health Care. Austin, Texas. 2003

Evidence Based Medicine. Excellence at Work Conference, Empire State Advantage. Albany, New York. 2002

Evidence Based Medicine, Outcomes Research, and Health Care Organizations. National Clinical Advisory Group, Integrail, Inc., Albany, New York. 2002

Evidence Based Medicine. With Dr. LK Hohmann. The Empire State Advantage, Annual Excellence at Work Conference: Leading and Managing for Organizational Excellence, Albany, New York. 2002

Taking the Mystery out of Evidence Based Medicine: Providing Useful Answers for Clinicians and Patients. Breakfast Series, Institute for the Advancement of Health Care Management, School of Business, University at Albany, Albany, New York. 2001

Diagnosis and Management of Male Erectile Dysfunction – A Goal-Oriented Approach. Society of General Internal Medicine National Meeting, San Francisco, California. 1999

Study Design and Critical Appraisal of the Literature. Graduate Medical Education Lecture Series for all housestaff, Albany Medical College, Albany, New York. 1999

Male Impotence: Its Diagnosis and Treatment in the Era of Sildenafil. 4th Annual CME Day, Alumni Association of the Albany-Hudson Valley Physician Assistant Program, Albany, New York. 1998

Models For Measuring Physician Productivity. Panelist. National Association of VA Ambulatory Managers National Meeting, Memphis, Tennessee. 1997

Introduction to Male Erectile Dysfunction and the Role of Sildenafil in Treatment. Northeast Regional Meeting Pfizer Sales Representatives, Manchester Center, Vermont. 1997

Male Erectile Dysfunction. Topics in Urology, A Seminar for Primary Healthcare Providers, Bassett Healthcare, Cooperstown, New York. 1997

Evaluation and Treatment of the Patient with Impotence: A Practical Primer for General Internists. Society of General Internal Medicine National Meeting, Washington D.C. 1996

Impotence: An Update. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1996

Diabetes for the EMT First-Responder. Five Quad Volunteer Ambulance, University at Albany. Albany, New York. 1996

Impotence: An Approach for Internists. Medicine Grand Rounds, St. Mary's Hospital, Rochester, New York. 1994

Male Impotence. Common Problems in Primary Care Precourse. American College of Physicians National Meeting, Miami, Florida. 1994

Patient Motivation: A Key to Success. Tuberculosis and HIV: A Time for Teamwork. AIDS Program, Bureau of Tuberculosis Control – New York State Department of Health and Albany Medical College, Albany, New York. 1994

Recognizing and Treating Impotence. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1992

Medical Decision Making: A Primer on Decision Analysis. Faculty Research Seminar, Department of Family Practice, Indiana University, Indianapolis, Indiana. 1992

Effective Presentation of Public Health Data. Bureau of Communicable Diseases, Indiana State Board of Health, Indianapolis, Indiana. 1991

Impotence: An Approach for Internists. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Using Electronic Databases to Search the Medical Literature. NIH/VA Fellows Program, Indiana University, Indianapolis, Indiana. 1991

Study Designs Used in Epidemiology. Ambulatory Care Block Rotation. Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Effective Use of Slides in a Short Scientific Presentation. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Impotence: A Rational and Practical Approach to Diagnosis and Treatment for the General Internist. Society of General Internal Medicine National Meeting, Washington D.C. 1991

Nirvana and Audio-Visual Aids. With Dr. RM Lubitz. Society of General Internal Medicine, Midwest Regional Meeting, Chicago. 1991

New Perspectives in the Management of Hypercholesterolemia. Medical Staff, West Seneca Developmental Center, West Seneca, New York. 1989

Effective Use of Audio-Visual Aids. Nurse Educators, American Diabetes Association, Western New York Chapter, Buffalo, New York. 1989

Management of Diabetics in the Custodial Care Setting. Medical Staff, West Seneca Developmental Center, West Seneca, New York, 1989

Effective Use of Audio-Visuals in Diabetes Peer and Patient Education. American Association of Diabetic Educators, Western New York Chapter, Buffalo, New York. 1989

Pathophysiology, Diagnosis and Care of Diabetes. Nurse Practitioner Training Program, School of Nursing, University of Buffalo, Buffalo, New York. 1989

Techniques of Large Group Presentations to Medical Audiences – Use of Audio-Visuals. New Housestaff Training Program, Graduate Medical Dental Education Consortium of Buffalo, Buffalo, New York. 1988

PUBLICATIONS/ABSTRACTS

Borschmann, R, Tibble, H, Spittal, MJ, ... Stern, MF, Viner, KM, Wang, N, Willoughby, M, Zhao, B, and Kinner, SA. *The Mortality After Release from Incarceration Consortium (MARIC): Protocol for a multi-national, individual participant data meta-analysis.* Int. J of Population Data Science 2019 5(1):6

Binswanger IA, Maruschak LM, Mueller SR, **Stern MF**, Kinner SA. *Principles to Guide National Data Collection on the Health of Persons in the Criminal Justice System.* Public Health Reports 2019 134(1):34S-45S

Stern M. *Hunger Strike: The Inside Medicine Scoop.* American Jails 2018 32(4):17-21

Grande L, **Stern M.** *Providing Medication to Treat Opioid Use Disorder in Washington State Jails.* Study conducted for Washington State Department of Social and Health Services under Contract 1731-18409. 2018.

Stern MF, Newlin N. *Epicenter of the Epidemic: Opioids and Jails.* American Jails 2018 32(2):16-18

Stern MF. *A nurse is a nurse is a nurse...NOT!* Guest Editorial, American Jails 2018 32(2):4,68

Wang EA, Redmond N, Dennison Himmelfarb CR, Pettit B, **Stern M**, Chen J, Shero S, Iturriaga E, Sorlie P, Diez Roux AV. *Cardiovascular Disease in Incarcerated Populations.* Journal of the American College of Cardiology 2017 69(24):2967-76

Mitchell A, Reichberg T, Randall J, Aziz-Bose R, Ferguson W, **Stern M.** *Criminal Justice Health Digital Curriculum.* Poster, Annual Academic and Health Policy Conference on Correctional Health, Atlanta, Georgia, March, 2017

Stern MF. *Patient Safety (White Paper).* Guidelines, Management Tools, White Papers, National Commission on Correctional Health Care. <http://www.ncchc.org/filebin/Resources/Patient-Safety-2016.pdf>. June, 2016

Binswanger IA, **Stern MF**, Yamashita TE, Mueller SR, Baggett TP, Blatchford PJ. *Clinical risk factors for death after release from prison in Washington State: a nested case control study.* Addiction 2015 Oct 17

Stern MF. Op-Ed on Lethal Injections. The Guardian 2014 Aug 6

Stern MF. *American College of Correctional Physicians Calls for Caution Placing Mentally Ill in Segregation: An Important Band-Aid.* Guest Editorial. Journal of Correctional Health Care 2014 Apr; 20(2):92-94

Binswanger I, Blatchford PJ, Mueller SR, **Stern MF.** *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009.* Annals of Internal Medicine 2013 Nov; 159(9):592-600

Williams B, **Stern MF**, Mellow J, Safer M, Greifinger RB. *Aging in Correctional Custody: Setting a policy agenda for older prisoner health care.* American Journal of Public Health 2012 Aug; 102(8):1475-1481

Binswanger I, Blatchford PJ, Yamashita TE, **Stern MF.** *Drug-Related Risk Factors for Death after Release from Prison: A Nested Case Control Study.* Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Blatchford PJ, Forsyth S, **Stern MF**, Kinner SA. *Death Related to Infectious Disease in Ex-Prisoners: An International Comparative Study.* Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Lindsay R, **Stern MF**, Blatchford P. *Risk Factors for All-Cause, Overdose and Early Deaths after Release from Prison in Washington State Drug and Alcohol Dependence.* Drug and Alcohol Dependence Aug 1 2011;117(1):1-6

Stern MF, Greifinger RB, Mellow J. *Patient Safety: Moving the Bar in Prison Health Care Standards.* American Journal of Public Health November 2010;100(11):2103-2110

Strick LB, Saucerman G, Schlatter C, Newsom L, **Stern MF.** *Implementation of Opt-Out HIV testing in the Washington State Department of Corrections.* Poster Presentation, National Commission on Correctional Health Care Annual Meeting, Orlando, Florida, October, 2009

Binswanger IA, Blatchford P, **Stern MF.** *Risk Factors for Death After Release from Prison.* Society for General Internal Medicine 32nd Annual Meeting; Miami: Journal of General Internal Medicine; April 2009. p. S164-S95

Stern MF. Force Feeding for Hunger Strikes – One More Step. CorrDocs Winter 2009;12(1):2

Binswanger I, **Stern MF**, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. *Release from Prison – A High Risk of Death for Former Inmates.* New England Journal of Medicine 2007 Jan 11;356(2):157–165

Stern MF, Hilliard T, Kelm C, Anderson E. *Epidemiology of Hepatitis C Infection in the Washington State Department of Corrections.* Poster Presentation, CDC/NIH ad hoc Conference on Management of Hepatitis C in Prisons, San Antonio, Texas, January, 2003

Phelps KR, **Stern M**, Slingerland A, Heravi M, Strogatz DS, Haqqie SS. *Metabolic and skeletal effects of low and high doses of calcium acetate in patients with preterminal chronic renal failure.* Am J Nephrol 2002 Sep–Dec;22(5–6):445–54

Goldberg L, **Stern MF**, Posner DS. *Comparative Epidemiology of Erectile Dysfunction in Gay Men.* Oral Presentation, International Society for Impotence Research Meeting, Amsterdam, The Netherlands, August 1998. Int J Impot Res. 1998;10(S3):S41 [also presented as oral abstract Annual Meeting, Society for the Study of Impotence, Boston, Massachusetts, October, 1999. Int J Impot Res. 1999;10(S1):S65]

Stern MF. *Erectile Dysfunction in Older Men.* Topics in Geriatric Rehab 12(4):40–52, 1997. [republished in Geriatric Patient Education Resource Manual, Supplement. Aspen Reference Group, Eds. Aspen Publishers, Inc., 1998]

Stern MF, Wulfert E, Barada J, Mulchahy JJ, Korenman SG. *An Outcomes–Oriented Approach to the Primary Care Evaluation and Management of Erectile Dysfunction.* J Clin Outcomes Management 5(2):36–56, 1998

Fihn SD, Callahan CM, Martin D, et al.; for the **National Consortium of Anticoagulation Clinics.*** *The Risk for and Severity of Bleeding Complications in Elderly Patients Treated with Warfarin.* Ann Int Med. 1996;124:970–979

Fihn SD, McDonnell M, Martin D, et al.; for the **Warfarin Optimized Outpatient Follow-up Study Group.*** *Risk Factors for Complications of Chronic Anticoagulation.* Ann Int Med. 1993;118:511–520. (*While involved in the original proposal development and project execution, I was no longer part of the group at the time of this publication)

Stern MF, Dittus RS, Birkhead G, Huber R, Schwartz J, Morse D. *Cost–Effectiveness of Hepatitis B Immunization Strategies for High Risk People.* Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonnell MB, Vermes D, Martin D, Kent DL, Henikoff JG, and the **Warfarin Outpatient Follow-up Study Group**. *Optimal Scheduling of Patients Taking Warfarin. A Multicenter Randomized Trial*. Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonnell MB, Vermes D, Kent DL, Henikoff JG, and the **Warfarin Anticoagulation Study Group**. *Risk Factors for Complications During Chronic Anticoagulation*. Poster Presentation, Society of General Internal Medicine National Meeting, Seattle, May 1991

Pristach CA, Donoghue GD, Sarkin R, Wargula C, Doerr R, Opila D, **Stern M**, Single G. *A Multidisciplinary Program to Improve the Teaching Skills of Incoming Housestaff*. Acad Med. 1991;66(3):172–174

Stern MF. *Diagnosing Chlamydia trachomatis and Neisseria gonorrhea Infections*. (letter) J Gen Intern Med. 1991;6:183

Stern MF, Fitzgerald JF, Dittus RS, Tierney WM, Overhage JM. *Office Visits and Outcomes of Care: Does Frequency Matter?* Poster Presentation, Society of General Internal Medicine Annual Meeting, Seattle, May 1991. Clin Res 1991;39:610A

Stern MF. *Cobalamin Deficiency and Red Blood Cell Volume Distribution Width*. (letter) Arch Intern Med. 1990;150:910

Stern M, Steinbach B. *Hypodermic Needle Embolization to the Heart*. NY State J Med. 1990;90(7):368–371

Stern MF, Birkhead G, Huber R, Schwartz J, Morse D. *Feasibility of Hepatitis B Immunization in an STD Clinic*. Oral Presentation, American Public Health Association Annual Meeting, Atlanta, November 1990

EXPERT TESTIMONY

Pajas v. County of Monterey, *et al.* US District Court for the Northern District of California, 2019 (trial)

Dockery, *et al.* v. Hall *et al.* US District Court for the Southern District of Mississippi Northern Division, 2018 (trial)

Benton v. Correct Care Solutions, *et al.* US District Court for the District of Maryland, 2018 (deposition)

Pajas v. County of Monterey, *et al.* US District Court Northern District of California, 2018 (deposition)

Walter v. Correctional Healthcare Companies, *et al.* US District Court, District of Colorado, 2017 (deposition)

Winkler v. Madison County, Kentucky, *et al.* US District Court, Eastern District of Kentucky, Central Division at Lexington, 2016 (deposition)

US v. Miami-Dade County, *et al.* US District Court, Southern District of Florida, periodically 2014 - 2016

Exhibit 2

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

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

II. Heightened Risk of Epidemics in Jails and Prisons

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

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

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

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

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

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

III. Profile of COVID-19 as an Infectious Disease⁴

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Conclusion and Recommendations

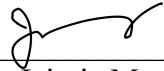
36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These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

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

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

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

March 15, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

EXHIBIT A

CURRICULUM VITAE

Date of Revision: November 20, 2019
 Name: Jaimie Meyer, MD, MS, FACP
 School: Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
 MD, University of Connecticut School of Medicine 2005
 MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008 Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
 2008 - 2011 Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
 2008 - 2012 Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
 2010 - 2012 Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
 2012 - 2014 Instructor, AIDS, Yale School of Medicine, New Haven, CT
 2014 - present Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
 2015 - 2018 Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
 AB of Internal Medicine, Infectious Disease, 10-2010
 AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018 NIH Center for Scientific Review, Selected as Early Career Reviewer
 2017 Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
 2016 American College of Physicians, Fellow
 2016 NIH Health Disparities, Loan Repayment Award Competitive Renewal
 2016 AAMC, Early Career Women Faculty Professional Development Seminar
 2014 NIH Health Disparities, Loan Repayment Program Award
 2014 NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
 2014 International Women's/Children's Health & Gender Working Group, Travel Award
 2014 Patterson Trust, Awards Program in Clinical Research
 2013 Connecticut Infectious Disease Society, Thornton Award for Clinical Research
 2011 Bristol Myers-Squibb, Virology Fellows Award

2006	NY Columbia Presbyterian, John N. Loeb Intern Award
2005	American Medical Women's Association, Medical Student Citation
2005	Connecticut State Medical Society, Medical Student Award
2000	Dartmouth College, Hannah Croasdale Senior Award
2000	Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University

2014	Women's Faculty Forum, Public Voices Thought Leadership Program Fellow
------	--

Grants/Clinical Trials History:

Current Grants

Agency:	Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#:	2019-20 Pilot Project Awards
Title:	Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.:	Tiara Willie
Role:	Principal Investigator
Percent effort:	2%
Direct costs per year:	\$29,993.00
Total costs for project period:	\$29,993.00
Project period:	7/11/2019 - 7/10/2020

Agency:	SAMHSA
I.D.#:	H79 TI080561
Title:	CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role:	Principal Investigator
Percent effort:	20%
Direct costs per year:	\$389,054.00
Total costs for project period:	\$1,933,368.00
Project period:	11/30/2018 - 11/29/2023

Agency:	Gilead Sciences, Inc.
I.D.#:	Investigator Sponsored Award, CO-US-276-D136
Title:	Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role:	Principal Investigator
Percent effort:	8%
Direct costs per year:	\$81,151.00
Total costs for project	

period: \$306,199.00
 Project period: 6/19/2018 - 1/31/2020

Agency: NIDA
 I.D.#: R21 DA042702
 Title: Prisons, Drug Injection and the HIV Risk Environment
 Role: Principal Investigator
 Percent effort: 22%
 Direct costs per year: \$129,673.00
 Total costs for project period: \$358,276.00
 Project period: 8/1/2017 - 7/31/2020

Agency: Doris Duke Charitable Foundation
 I.D.#: Clinical Scientist Development Award
 Title: Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
 Role: Principal Investigator
 Percent effort: 27%
 Direct costs per year: \$149,959.00
 Total costs for project period: \$493,965.00
 Project period: 7/1/2017 - 6/30/2020

Past Grants

Agency: NIDA
 I.D.#: K23 DA033858
 Title: Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
 Role: Principal Investigator
 Percent effort: 75%
 Direct costs per year: \$149,509.00
 Total costs for project period: \$821,147.00
 Project period: 7/1/2012 - 11/30/2017

Agency: Robert Leet & Clara Guthrie Patterson Trust
 I.D.#: R12225, Award in Clinical Research
 Title: Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
 Role: Principal Investigator
 Percent effort: 10%
 Direct costs per year: \$75,000.00

Total costs for project

period: \$75,000.00
 Project period: 1/31/2014 - 10/31/2015

Agency: Bristol-Myers Squibb
 I.D.#: HIV Virology Fellowship Award
 Title: Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
 Role: Principal Investigator
 Percent effort: 10%
 Direct costs per year: \$34,390.00
 Total costs for project
 period: \$34,390.00
 Project period: 12/1/2011 - 11/30/2012

Pending Grants

Agency: NIMH
 I.D.#: R01 MH121991
 Title: Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
 P.I.: Sullivan, Tami
 Role: Principal Investigator
 Percent effort: 30%
 Direct costs per year: \$499,755.00
 Total costs for project
 period: \$4,148,823.00
 Project period: 1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:**International/National**

- 2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"
- 2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"
- 2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"
- 2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"
- 2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"
- 2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

- 2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"
- 2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"
- 2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"
- 2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"
- 2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:

International/National

- 2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"
- 2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"
- 2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"
- 2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"
- 2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"
- 2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""
- 2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"
- 2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"
- 2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"
- 2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

- 2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"
- 2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"
- 2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"
- 2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"
- 2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"
- 2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"
- 2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"
- 2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"
- 2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"
- 2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

- 2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"
- 2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"
- 2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"
- 2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"
- 2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"
- 2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

- 2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"
- 2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"
- 2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

- 2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

- 2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers
- 2019 - present Reviewer, Yale DCFAR Pilot Projects
- 2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)
- 2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

- 2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

- 2019 - present Associate Editor, Journal of the International Association of Providers of AIDS Care (JIAPAC), Section Editor: Sex and Gender Issues

Reviewer

- 2019 - present Reviewer, JAIDS
- 2012 - present Reviewer, Addiction Sci and Clin Pract
- 2012 - present Reviewer, Addictive Behav Reports
- 2012 - present Reviewer, AIDS Care
- 2012 - present Reviewer, Social Science and Medicine
- 2012 - present Reviewer, SpringerPlus
- 2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy
- 2012 - present Reviewer, Women's Health Issues
- 2012 - present Reviewer, Yale Journal of Biology and Medicine
- 2012 - present Reviewer, AIMS Public Health
- 2012 - present Reviewer, American Journal on Addictions
- 2012 - present Reviewer, American Journal of Epidemiology
- 2012 - present Reviewer, American Journal of Public Health
- 2012 - present Reviewer, Annals Internal Medicine
- 2012 - present Reviewer, BMC Emergency Medicine
- 2012 - present Reviewer, BMC Infectious Diseases
- 2012 - present Reviewer, BMC Public Health
- 2012 - present Reviewer, BMC Women's Health

2012 - present Reviewer, Clinical Infectious Diseases
 2012 - present Reviewer, Critical Public Health
 2012 - present Reviewer, Drug and Alcohol Dependence
 2012 - present Reviewer, Drug and Alcohol Review
 2012 - present Reviewer, Epidemiologic Reviews
 2012 - present Reviewer, Eurosurveillance
 2012 - present Reviewer, Health and Justice (Springer Open)
 2012 - present Reviewer, International Journal of Drug Policy
 2012 - present Reviewer, International Journal of Prisoner Health
 2012 - present Reviewer, International Journal of STDs and AIDS
 2012 - present Reviewer, International Journal of Women's Health
 2012 - present Reviewer, JAMA Internal Medicine
 2012 - present Reviewer, Journal of Family Violence
 2012 - present Reviewer, Journal of General Internal Medicine
 2012 - present Reviewer, Journal of Immigrant and Minority Health
 2012 - present Reviewer, Journal of International AIDS Society
 2012 - present Reviewer, Journal of Psychoactive Drugs
 2012 - present Reviewer, Journal of Urban Health
 2012 - present Reviewer, Journal of Women's Health
 2012 - present Reviewer, Open Forum Infectious Diseases
 2012 - present Reviewer, PLoS ONE
 2012 - present Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

2016 - present Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians

2016 - present Fellow, American College of Physicians
 2013 - 2016 Member, American College of Physicians

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine

2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School

2013 - present Mentor, Women in Medicine at Yale Mentoring Program

2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS

2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

1. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Emergency department use by released prisoners with HIV: an observational longitudinal study. PloS One 2012, 7:e42416.
2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. Journal Of Immigrant And Minority Health / Center For Minority Public Health 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. AIDS And Behavior 2013, 17 Suppl 2:S118-27.

4. Chen NE, **Meyer JP**, Avery AK, Draine J, Flanigan TP, Lincoln T, Spaulding AC, Springer SA, Altice FL. Adherence to HIV treatment and care among previously homeless jail detainees. *AIDS And Behavior* 2013, 17:2654-66.
5. Althoff AL, Zelenev A, **Meyer JP**, Fu J, Brown SE, Vagenas P, Avery AK, Cruzado-Quñones J, Spaulding AC, Altice FL. Correlates of retention in HIV care after release from jail: results from a multi-site study. *AIDS And Behavior* 2013, 17 Suppl 2:S156-70.
6. Williams CT, Kim S, **Meyer J**, Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. *AIDS And Behavior* 2013, 17 Suppl 2:S195-202.
7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. *International Journal Of Prisoner Health* 2013, 9:124-41.
8. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Frequent emergency department use among released prisoners with human immunodeficiency virus: characterization including a novel multimorbidity index. *Academic Emergency Medicine : Official Journal Of The Society For Academic Emergency Medicine* 2013, 20:79-88.
9. **Meyer JP**, Cepeda J, Springer SA, Wu J, Trestman RL, Altice FL. HIV in people reincarcerated in Connecticut prisons and jails: an observational cohort study. *The Lancet. HIV* 2014, 1:e77-e84.
10. **Meyer JP**, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender disparities in HIV treatment outcomes following release from jail: results from a multicenter study. *American Journal Of Public Health* 2014, 104:434-41.
11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. *JAMA Internal Medicine* 2014, 174:721-9.
12. **Meyer JP**, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. *American Journal Of Public Health* 2015, 105:1901-10.
13. Boyd AT, Song DL, **Meyer JP**, Altice FL. Emergency department use among HIV-infected released jail detainees. *Journal Of Urban Health : Bulletin Of The New York Academy Of Medicine* 2015, 92:108-35.
14. Shrestha R, Karki P, Altice FL, Huedo-Medina TB, **Meyer JP**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and anticipation of practicing safer drug- and sex-related behaviors among high-risk drug users on methadone treatment. *Drug And Alcohol Dependence* 2017, 173:107-116.
15. Peasant C, Sullivan TP, Weiss NH, Martinez I, **Meyer JP**. Beyond the syndemic: condom negotiation and use among women experiencing partner violence. *AIDS Care* 2017, 29:516-523.
16. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, **Meyer JP**, El-Bassel N, Mayer KH, Kamarulzaman A, Altice FL. Prevalence of Human Immunodeficiency Virus and Sexually Transmitted Infections Among Cisgender and Transgender Women Sex Workers in Greater Kuala Lumpur, Malaysia: Results From a Respondent-Driven Sampling Study. *Sexually Transmitted Diseases* 2017, 44:663-670.
17. Hoff E, Marcus R, Bojko MJ, Makarenko I, Mazhnaya A, Altice FL, **Meyer JP**. The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. *Journal Of Substance Abuse Treatment* 2017, 83:36-44.

18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. *AIDS Care* 2018, 30:1282-1289.
19. Peasant C, Sullivan TP, Ritchwood TD, Parra GR, Weiss NH, **Meyer JP**, Murphy JG. Words can hurt: The effects of physical and psychological partner violence on condom negotiation and condom use among young women. *Women & Health* 2018, 58:483-497.
20. Loeliger KB, Altice FL, Desai MM, Ciarleglio MM, Gallagher C, **Meyer JP**. Predictors of linkage to HIV care and viral suppression after release from jails and prisons: a retrospective cohort study. *The Lancet. HIV* 2018, 5:e96-e106.
21. Odio CD, Carroll M, Glass S, Bauman A, Taxman FS, **Meyer JP**. Evaluating concurrent validity of criminal justice and clinical assessments among women on probation. *Health & Justice* 2018, 6:7.
22. Loeliger KB, Altice FL, Ciarleglio MM, Rich KM, Chandra DK, Gallagher C, Desai MM, **Meyer JP**. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. *The Lancet. HIV* 2018, 5:e617-e628.
23. Loeliger KB, **Meyer JP**, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. *PLoS Medicine* 2018, 15:e1002667.
24. Azbel L, Wegman MP, Polonsky M, Bachireddy C, **Meyer J**, Shumskaya N, Kurmanalieva A, Dvoryak S, Altice FL. Drug injection within prison in Kyrgyzstan: elevated HIV risk and implications for scaling up opioid agonist treatments. *International Journal Of Prisoner Health* 2018, 14:175-187.
25. Peasant C, Montanaro EA, Kershaw TS, Parra GR, Weiss NH, **Meyer JP**, Murphy JG, Ritchwood TD, Sullivan TP. An event-level examination of successful condom negotiation strategies among young women. *Journal Of Health Psychology* 2019, 24:898-908.
26. Ranjit YS, Azbel L, Krishnan A, Altice FL, **Meyer JP**. Evaluation of HIV risk and outcomes in a nationally representative sample of incarcerated women in Azerbaijan, Kyrgyzstan, and Ukraine. *AIDS Care* 2019, 31:793-797.
27. Rhodes T, Azbel L, Lancaster K, **Meyer J**. The becoming-methadone-body: on the onto-politics of health intervention translations. *Sociology Of Health & Illness* 2019, 41:1618-1636.
28. Olson B, Vincent W, **Meyer JP**, Kershaw T, Sikkema KJ, Heckman TG, Hansen NB. Depressive symptoms, physical symptoms, and health-related quality of life among older adults with HIV. *Quality Of Life Research : An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation* 2019.

Chapters, Books, and Reviews

29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. *Drug And Alcohol Dependence* 2010, 112:178-93.
30. **Meyer JP**, Springer SA, Altice FL. Substance abuse, violence, and HIV in women: a literature review of the syndemic. *Journal Of Women's Health (2002)* 2011, 20:991-1006.
31. **Meyer JP**, Chen NE, Springer SA. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. *AIDS Research And Treatment* 2011, 2011:680617.
32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. *Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America* 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. *Infectious Disease Reports* 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. *Sexually Transmitted Infections* 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. *Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America* 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. *Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award)*. Oxford University Press 2015. ISBN 9780199360574.
37. **Meyer JP**, Moghimi Y, Marcus R, Lim JK, Litwin AH, Altice FL. Evidence-based interventions to enhance assessment, treatment, and adherence in the chronic Hepatitis C care continuum. *The International Journal On Drug Policy* 2015, 26:922-35.
38. Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J**. *Infectious Diseases in Underserved Populations*. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. *Current Diagnosis and Treatment- Infectious Diseases*. McGraw-Hill Medical 2016.
39. **Meyer JP**, Womack JA, Gibson B. Beyond the Pap Smear: Gender-responsive HIV Care for Women. *The Yale Journal Of Biology And Medicine* 2016, 89:193-203.
40. **Meyer JP**, Muthulingam D, El-Bassel N, Altice FL. Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions. *AIDS And Behavior* 2017, 21:3527-3548.
41. Shrestha R, McCoy-Redd B, **Meyer J**. Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. *The Opioid Epidemic and Infectious Diseases*. Elsevier 2019.
42. **Meyer JP**, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. *Drug And Alcohol Dependence* 2019, 197:158-163.

Peer-Reviewed Educational Materials

43. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014
44. United Nations Office on Drugs and Crime. Vienna, Austria

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. *Journal Of General Internal Medicine* 2014, 29:1164.
46. Brinkley-Rubinstein L, Dauria E, Tolou-Shams M, Christopoulos K, Chan PA, Beckwith CG, Parker S, **Meyer J**. The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems. *Current HIV/AIDS Reports* 2018, 15:93-95.
47. **Meyer JP**. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. *Journal Of Women's Health (2002)* 2019, 28:1017-1018.

Case Reports, Technical Notes, Letters

48. **Paul J.** Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
49. How J, Azar MM, **Meyer JP.** Are Nectarines to Blame? A Case Report and Literature Review of Spontaneous Bacterial Peritonitis Due to *Listeria monocytogenes*. Connecticut Medicine 2015, 79:31-6.
50. Vazquez Guillaumet LJ, Malinis MF, **Meyer JP.** Emerging role of *Actinomyces meyeri* in brain abscesses: A case report and literature review. IDCases 2017, 10:26-29.
51. Harada K, Heaton H, Chen J, Vazquez M, **Meyer J.** Zoster vaccine-associated primary varicella infection in an immunocompetent host. BMJ Case Reports 2017, 2017.
52. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP.** Answer to December 2017 Photo Quiz. Journal Of Clinical Microbiology 2017, 55:3568.
53. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP.** Photo Quiz: Peripheral Blood Smear in a Ugandan Refugee. Journal Of Clinical Microbiology 2017, 55:3313-3314.

Scholarship In Press

54. Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health

Exhibit 3

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION**

RUSSELL, et al.	)	
Plaintiffs,	)	
v.	)	Case No. 4:19-cv-00226
HARRIS COUNTY, TEXAS, et al.	)	(Class Action)
Defendants.	)	The Honorable Lee H. Rosenthal
	)	U.S. District Judge
	)	

Declaration of Dr. Chiao

I. Background and Qualifications

1. I am Dr. Elizabeth Chiao, Professor of Medicine, Division of Infectious Diseases and Health Services, Research, Baylor College of Medicine. I am board certified by the American Board of Internal Medicine (ABIM) in Medical Oncology and Infectious Diseases. I am licensed to practice medicine in the state of Texas, license number L8647. I earned my Doctor of Medicine from Cornell University Medical College, and Master Degree in Public Health from Yale University School of Medicine, Department of Epidemiology and Public Health. I completed my residency at the University of Utah, and completed Fellowships in Medical Oncology at Memorial Sloan Kettering, and in Infectious Diseases at Baylor College of Medicine.
2. I have worked for the past 14 years as Faculty in the Division of Infectious Diseases and Health Services Research at Baylor College of Medicine. My research interests focus on the epidemiology, prevention, treatment and outcomes of HIV-related comorbidities and Cancers, as well as health disparities for people living with HIV.
3. In the past 14 years I have received continuous funding by the National Institutes of Health (NIH) starting with an NCI funded K23 (K23 CA124318) in 2006. I subsequently received an NCI funded R01 (R01CA163103) entitled "The Effectiveness of Screening HIV-infected Women for Anal Cancer Precursors," and a second R01 (R01CA206476) "(PQ 3) Identifying Novel Pharmacologic Risk factors for Common Non-AIDS Defining Cancers in Individuals with Well-controlled HIV Infection." I am additionally a co-investigator on multiple national NIH funded projects. I also hold several leadership positions in the AIDS Malignancy Consortium (AMC): I am 1) the Baylor College of Medicine principal investigator for the AMC, 2) the co-chair of AMC 087: a phase 1 protocol of Cabozantinib for the treatment of advanced solid tumors in HIV-infected individuals (currently enrolling), and 3) the

chair of the Solid Tumor Working Group in the AMC. Furthermore, I collaborate with U.S.-based and international researchers and I have been appointed to several national and international committees including the Board of Scientific Advisers subcommittee for HIV-related malignancies, scientific merit review committees for South Africa and the organizing committee for the International HIV Malignancy Conference. My clinical work as the clinical director of both the Anal Dysplasia and Medical Oncology clinics at the Thomas Street Health Center were recognized with a Baylor Clinician STAR award in 2017. Finally, I lead an active mentoring program where several mentees have successfully applied for and obtained career development awards and other various research funding. In summary, I am a clinician researcher whose goals are to improve survival and quality of life for people living with HIV (HIV), and individuals with virally mediated cancer by improving cancer prevention, screening and treatment outcomes.

4. I have written and published extensively on the topics of infectious diseases, and the epidemiology of people living with HIV (PLWH), including papers about PLWH involved in the criminal justice system. In particular, I have published in leading peer-reviewed journals on the health disparities and the ethical medical care for PLWH for people in detention; disparities in the outcomes of AIDS-related Kaposi Sarcoma; and how to improve screening for Human Papillomavirus-related cancers in PLWH to take just three examples.
5. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
6. I am donating my time reviewing materials and preparing this report. Any live testimony I provide will also be provided *pro bono*.
7. I have not testified as an expert at trial or by deposition in the past four years.
8. This declaration is substantially the same as a sworn declaration submitted by Dr. Jaimie Meyer, Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut, in federal court in New York. CITE. Dr. Meyer is board certified in Internal Medicine, Infectious Diseases and Addiction Medicine.
9. I have reviewed thoroughly Dr. Meyer's report, and the sources cited in it. Based on my own independent training, expertise, and experience in epidemiology and infectious diseases, I fully agree with Dr. Meyer's analysis of the dangers that the novel corona posed in New York City-area jails, and believe that they are applicable, as described below, to the Harris County jail.

II. Heightened Risk of Epidemics in Jails and Prisons

10. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to

individuals who become infected. There are several reasons this is the case, as delineated further below.

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

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

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

care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

21. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public. Furthermore, rapid spread of infectious diseases among the inmates can often worsen the epidemic outside of the incarcerated population because staff are more likely to be infected and spread the disease to their families and the wider population.
22. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.² Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.³ Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease⁴

23. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but recent data from China has demonstrated that almost 13% of transmission occurs from asymptomatic individuals before they start to show symptoms, and it is possible that transmission can occur for weeks after their symptoms resolve.⁵ In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the

² *Influenza Outbreaks at Two Correctional Facilities—Maine, March 2011*, Centers for Disease Control and Prevention (2012), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

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

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

⁵ Du Z, Xu X, Wu Y, Wang L, Cowling BJ, Ancel Meyers L. Serial interval of COVID-19 among publicly reported confirmed cases. *Emerg Infect Dis.* 2020 Jun [date cited]. <https://doi.org/10.3201/eid2606.200357>

virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for over a year to the general public. Antiviral medications are currently in testing but not yet FDA-approved. People in prison and jail will likely have even less access to these novel health strategies as they become available.

24. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.⁶ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.⁷ Among those individuals, the risk of poor outcomes, included the need for mechanical intervention is over 20%. Death in COVID-19 infection is usually due to pneumonia, and sepsis, and would occur between approximately 1-4% of the population. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.
25. The care of people who are infected with COVID-19 depends on how seriously they are ill.⁸ People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
26. In order to prevent overwhelming the local health systems, aggressive containment and COVID-19 prevention is of utmost importance. To this end, certain states and jurisdictions, including Harris County have mandated COVID-19 prevention strategies, such as “shelter in place” or “stay at home”, which have gone beyond containment and mitigation. Jails and prisons already have difficulty with containment because it requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. However, even with these efforts, it is nearly impossible for

⁶ *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html.

⁷ *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*, *The Lancet* (published online March 11, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext).

⁸ *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

jails and prisons to provide the atmosphere of “shelter in place” or “stay at home” social distancing, given the number of individuals that work in and are housed in these facilities in the current system. Decreasing the population will help the prison facilities to develop “isolation” strategies that can nearly mirror Harris County mandates.

27. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.⁹ To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.¹⁰ Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in the Harris County Jail

28. In preparing this report I have spoken with Dr. Marc Robinson, who has worked as a physician in the medical clinic in the jail and therefore has first-hand knowledge of the medical facilities and jail conditions in the Harris County Jail. Based on my conversation with Dr. Robinson, I understand that the medical facilities in the jail are rudimentary and are not equipped to care for anyone with an acute illness. The Harris County Jail cannot do anything other than administer oxygen, and supplies are limited. Thus, anyone whose symptoms are more severe than mild would be sent to the local hospital. This would cause significant strain on both the local hospital and jail/prison staff. Because people wait for administrative disposition, and are housed/live in close quarters, and because of the number of people detained of the Harris County Jail, it is impossible for inmates to comply with local health mandates and CDC recommendations, including social distancing. Moreover, because hundreds of people cycle in and out of the jail every day, it is virtually impossible to create stable units of people isolating those infected with those who are uninfected, which is necessary to contain infection.
29. Based on my conversations with Ms. Sarah Wood, Policy Director for the Harris County Office of the Public Defender, and Dr. Robinson, my experience working on public health and Infectious Diseases, and my review of the relevant literature, it is my professional judgment that the Harris County Jail is dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

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

¹⁰ *Luke Barr & Christina Carrega, State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), <https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690>.

30. Above and beyond the inability to prevent the spread of COVID-19 and increased risk for severe illness and inability to care for inmates in jail and prisons, the delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.
31. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.
32. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.
33. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.
34. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.
35. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.
36. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.
37. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.
38. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

39. For the reasons above, it is my professional judgment that individuals placed in the Harris County Jail are at a significantly higher risk of infection with COVID-19 as compared to the population in the community, given the procedural and housing conditions in the facilities, and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.
40. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for who both are housed and work within those facilities and for the community at large.
41. From a public health perspective, it is my strong opinion that individuals who can **safely and appropriately** remain in the community not be placed in the Harris County Jail at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release, and that a careful evaluation of procedural and housing guidance is created for those who remain in the facilities during the “stay at home” mandate, and possibly until the epidemic is contained.
42. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune systems, cancer, and diabetes) or who are over the age of 60.¹¹ They are in even greater danger in these facilities, including a meaningfully higher risk of death.
43. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks.
44. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

¹¹ *Report of the WHO-China Joint Mission of Coronavirus Disease 2019 (COVID-19)* (Feb. 16-24 2020), available at <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>.

I declare under penalty of perjury that the foregoing is true and correct to the best of my ability.

Simon

Name

3/27/2020

Date

EXHIBIT A
Curriculum Vitae

Personal statement

My research focuses on HIV clinical management, HIV co-morbidity research, HIV malignancy clinical management, and virally-mediated cancer research, with an emphasis on evaluating the epidemiology of HIV-associated cancers, cancer prevention and outcomes. My work involves both utilizing large databases and cohorts to improve cancer prevention strategies for HIV-infected individuals as well as clinical trial/clinical research elucidating the prevention and treatment of HIV-related cancers. My training in Epidemiology, HIV, Oncology, and Infectious Diseases make me uniquely qualified to conduct research in HIV-related and other viral malignancies. My group and I were the first to show the effect of cumulative measurements of combined antiretroviral therapy (cART) on multiple different HIV-associated cancers utilizing VA administrative databases. We have over 20 publications on HIV-associated malignancies focusing on elucidating the impact of HIV-related factors on the incidence of HIV-related malignancies in high impact journals such as *JAMA*, *the Journal of Clinical Oncology*, *Clinical Infectious Diseases*, and the *Journal of Acquired Immune Deficiency Syndromes*. In the past 12 years I have received continuous funding by the National Institutes of Health (NIH) starting with an NCI funded K23 (K23 CA124318) in 2006. I subsequently received an NCI funded R01 (R01CA163103) entitled "The Effectiveness of Screening HIV-infected Women for Anal Cancer Precursors," and a second R01 (R01CA206476) "(PQ 3) Identifying Novel Pharmacologic Risk factors for Common Non-AIDS Defining Cancers in Individuals with Well-controlled HIV Infection." I am additionally a co-investigator on multiple national NIH funded projects. I also hold several leadership positions in the AIDS Malignancy Consortium (AMC): I am 1) the Baylor College of Medicine principal investigator for the AMC, 2) the co-chair of AMC 087: a phase 1 protocol of Cabozantinib for the treatment of advanced solid tumors in HIV-infected individuals (currently enrolling), and 3) the chair of the Solid Tumor Working Group in the AMC. Given my research productivity and expertise, I was recently selected to co-lead the Mechanisms of Cancer Evolution Scientific Working Group in the Dan L. Duncan Cancer Center. Furthermore, I collaborate with U.S.-based and international researchers and I have been appointed to several national and international committees including the Board of Scientific Advisers subcommittee for HIV-related malignancies, scientific merit review committees for South Africa and the organizing committee for the International HIV Malignancy Conference. My clinical work as the clinical director of both the Anal Dysplasia and Medical Oncology clinics at the Thomas Street Health Center were recognized with a Baylor Clinician STAR award in 2017. Finally, I lead an active mentoring program where several mentees have successfully applied for and obtained career development awards and other various research funding. In summary, I am a clinician researcher whose goals are to improve survival and quality of life for HIV-infected individuals, and individuals with virally mediated cancer by improving cancer prevention, screening and treatment outcomes.

I. GENERAL BIOGRAPHICAL INFORMATION**A. Personal**

1. Name: Elizabeth Yu Chiao, MD, MPH
2. Date of Birth: 7/13/1969; citizenship: USA
3. Home Address: 416 Byrne St. Houston, TX 77009
4. Office Address: Houston VA Medical Center (152), 2002 Holcombe Blvd, Houston, TX 77030
5. Office Phone Number: 713-440-4485
6. Email: echiao@bcm.edu

B. Education:

1. Undergraduate Education:
 - a. Cornell University, Ithaca, NY, School of Arts, (Biology and Society), May 1990
2. Medical Education or Graduate Education (with thesis/dissertation title, advisor):
 - a. Yale University School of Medicine, New haven, CT, Department of Epidemiology and Public Health, Master Degree in Public Health, December 1993, Graduated with Distinction, Thesis Title: Survival Analysis of Connecticut AIDS Cases reported through 1990
 - b. Cornell University Medical College, New York, NY, Doctor of Medicine, May 1998
3. Postgraduate Training: residency, fellowship (clinical or research), with source of support and advisor, if relevant):

- a. University of Utah, Salt Lake City, UT, Internal Medicine Department, Resident House staff, June 1998-2001
- b. Postgraduate Training-Fellowship: Memorial Sloan Kettering Cancer Center, New York, NY, Department of Medicine, Medical Oncology Clinical Research Fellow, Advisor: Susan Krown, July 2002-2004
- c. Postgraduate Training-Fellowship: Baylor College of Medicine, Houston, TX, Department of Medicine, Infectious Disease Fellow: July 2004-April 2005

C. Academic Appointments

1. Current Faculty position at BCM:
 - a. Professor, Internal Medicine, Infectious Diseases, Health Services Research Section, Center for Innovation in Quality, Effectiveness, and Safety, Michael E. DeBakey VA Medical Center, Baylor College of Medicine, 7/2018-present
 - b. Associate Professor, Internal Medicine, Infectious Diseases, Health Services Research Section, Center for Innovation in Quality, Effectiveness, and Safety, Michael E. DeBakey VA Medical Center, Baylor College of Medicine, 3/2014-7/2018
 - c. Assistant Professor, Internal Medicine, Infectious Diseases, Health Services Research Section Center for Innovation in Quality, Effectiveness, and Safety, Michael E. DeBakey VA Medical Center, Baylor College of Medicine, 1/2006-3/2014
 - d. Instructor, Internal Medicine, Infectious Diseases, 4/2005-1/2006
2. Previous faculty position at other institutions:
 - a. University of Utah, Salt Lake City, UT, Instructor, Department of Medicine. Attending physician in the HIV inpatient and outpatient services. Supervise and teach Internal Medicine house staff; 7/2001-7/2002

D. Other advanced training/experience:

1. Formal Sabbatical leave:
 - a. None
2. Other specialized training following academic appointment:
 - a. Trained high-resolution anoscopy (HRA). UCSF HRA training program 4/05

E. Other information:

1. **Honors or Awards: titles, dates:**
 - a. Heather Belsey Faculty Award, University of Utah 2002
 - b. MPH with Distinction 1993
 - c. Martin Luther King Community Service Award, Yale Medical School (1992)
 - d. Outstanding Reviewer Annals Internal Medicine 2007
 - e. Outstanding Reviewer Clinical Infectious Diseases Award 2008
 - f. NIH Loan Repayment Recipient 2007-2011
 - g. Baylor College of Medicine Star Clinician Award 2017
 - h. Co-Leader Mechanisms of Cancer Evolution, Dan L. Duncan NCI designated Cancer Center 2019

F. Board Certification:

1. Texas State License Number: Physician: L8647 exp: 5/31/2021
2. New York State License Number: Physicians and Surgeons: 224503-1
3. ABIM Board Certification
 - a. Internal Medicine Boards: Certified 08/2001 Exp: 8/2011
 - b. Internal Medicine Subspecialty Oncology: Certified 11/2004 Exp: 11/2024
 - c. Internal Medicine Subspecialty Inf Dis: Certified 11/2006 Exp: 11/2026
4. Other non-academic positions:
 - a. Board Member Voices Breaking Boundaries Non-Profit

- b. Board Member of University of Houston's Friends of Women's, Gender and Sexuality Studies

II. RESEARCH INFORMATION

A. Research Support

Current Research Funding:

- 1. (PQ3) Identifying Novel Pharmacologic Risk factors for Common Non-AIDS Defining Cancers in Individuals with Well-controlled HIV Infection**
 - a. National Institute of Health
 - b. Principal Investigator
 - c. June 2016-March 2020
 - d. \$1,968,930
 - e. 1R01 CA206476-01
- 2. The Effectiveness of High Resolution Microendoscopy (HRME) in High Grade Intraepithelial Lesions (HSIL) Diagnosis for People Living with HIV**
 - a. National Institute of Health
 - b. Co-Principal Investigator
 - c. November 2018-November 2023
 - d. \$2,100,000
 - e. R01 CA232890
- 3. AIDS Cancer Specimen Resource**
 - a. National Institute of Health, NCI
 - b. Co-Investigator
 - c. September 2013- December 2018
 - d. \$1,747,386 over 5 years
 - e. NIH UM1CA181255
 - f. PI: M. McGrath
- 4. Texas NeuroAIDS Repository**
 - a. National Institute of Health, NIMH
 - b. Co-Investigator (Baylor Principal Investigator)
 - c. February 2018-February 2023
 - d. \$650,000 over 5 years
 - e. U24MH100930
 - f. PI: B. Gelman
- 5. Annual Anal Sampling using DNA Screening to Identify Men Who have Sex with Men at Increased Risk for Anal Cancer**
 - a. National Institute of Health, NCI
 - b. Co-investigator
 - c. Sep 2017 - Aug 2022
 - d. \$380,613
 - e. R01CA215403-01A1
 - f. PI: A. Nyitray
- 6. AIDS Malignancy Clinical Trial Consortium**
 - a. National Institute of health, NCI
 - b. Co-investigator (Baylor Principal Investigator)
 - c. August 2015- August 2020
 - d. \$ 453,000
 - e. UM1CA121974
 - f. PI: R. Mitsuyasu
- 7. Immunogenetic determinants of HPV-related head and neck cancer in Veterans**
 - a. MEDVAMC
 - b. Co-Principal Investigator
 - c. April 2018 - March 2020
 - d. \$148,169

- e. VA 1 I01 BX004183-01A1
- 8. Determining the accuracy of self- and partner anal exams for detecting anal abnormalities**
 - a. National Institutes of Health, NCI
 - b. Co-investigator
 - c. Sept 2018-Aug 2023
 - d. \$ 1,100,173
 - e. R01CA232892-01
 - f. PI: A. Nyitray
- 9. Optimizing Age-Based Anal Cancer Screening Among People Living with HIV Using Decision Analytic Modeling**
 - a. National Institutes of Health, NCI
 - b. Co-Investigator
 - c. February 2019-February 2024
 - d. \$200,000
 - e. 1R01CA232888-01A1
 - f. PI: A. Deshmukh
- 10. A Randomized Controlled Trial of Mail-Self Stamped HPV Testing to Increase Cervical Cancer Screening Participation Among Minority/Underserved Women in an Integrated Safety Net Healthcare System**
 - a. National Institutes of Health, NIMHD
 - b. Co-Investigator
 - c. April 2019- April 2024
 - d. \$140,000
 - e. R01 MD013715-01
 - f. PI: J. Montealegre

Past Research Funding:

- 1. Pilot Study of Valganciclovir in Patients with Classic, non-HIV-associated Kaposi's Sarcoma
 - a. Roche Pharmaceuticals
 - b. Fellow
 - c. July 2004-July 2010
 - d. \$47,000
 - e. Pharmaceutical Grant
- 2. The Epidemiology of HIV-related Anal Dysplasia
 - a. Baylor Seed Fund Institutional Grant
 - b. Principal Investigator
 - c. July 2007-July 2008
 - d. \$25,000 (project support only)
- 3. Risk of Monoclonal Gammopathy of Undetermined Significance (MGUS) and Subsequent Multiple Myeloma (MM) among African American and White Veterans in the United States
 - a. Contract
 - b. National Cancer Institute
 - c. July 2007-July 2008
 - d. \$50,000 (project support only)
- 4. HPV-related cancers in HIV infected veterans
 - a. Pilot funds from HSR&D
 - b. Baylor College of Medicine
 - c. Principal Investigator
 - d. January 2009-December 2009
 - e. \$10,000
- 5. The Epidemiologic Effects of HAART on HIV-related Anal Cancer and Anal Dysplasia
 - a. K23 Patient-Oriented Mentored Career Development Award
 - b. National Institute of Cancer, NIH
 - c. Principal Investigator
 - d. July 2006-June 2011
 - e. \$637,500 over 5 years (80% salary and project funds)

6. NIH 1 K23 CA124318-06 K23 Patient-Oriented Mentored Career Development Award Supplement
 - a. National Institute of Cancer, NIH
 - b. Principal Investigator
 - c. September 2009-August 2011
 - d. \$100,000 over 2 years (project support only)
7. Behavioral Strategies to Accrue and Retain Diverse Underserved Populations in HIV Related Malignancy Clinical Trials
 - a. Supplement to U10CA139519-01A1
 - b. Co-Investigator
 - c. September 2011-September 2013
 - d. \$80,000
8. AIDS Cancer Specimen Registry (ACSR) Pilot Funds
 - a. Pilot Funds from the ACSR
 - b. UCSF
 - c. Principal Investigator
 - d. September 2009- September 2013
 - e. \$75,000 (project support only)
9. The Effect of HAART on the Epidemiology and Molecular Pathogenesis of HIV-related Hodgkin Lymphoma
 - a. Pilot Funds from the AIDS Malignancy Consortium (AMC)
 - b. Principal Investigator
 - c. May 2011-June 2014
 - d. \$65,000
 - e. NIH P30 CA125123
10. The Feasibility of Self/Partner-Assisted Digital Anal Exams for Cancer Screening
 - a. National Cancer Institute
 - b. Co-investigator
 - c. September 2013- September 2016
 - d. \$125,000
 - e. NIH R21 CA181901
11. The Effectiveness of Screening HIV-infected Women for Anal Cancer Precursors
 - a. National Institutes of Health, NCI
 - b. Principal Investigator
 - c. September 2011- August 2016
 - d. \$120,000
 - e. NIH 1 R01 CA163103 (S1)
12. Risk and Predictors of Esophageal and Esophagogastric Junction Adenocarcinomas in HIV-Infected Individuals
 - a. National Institute of Health, NIAID
 - b. Co-investigator
 - c. June 2016-December 2018
 - d. \$475,487
 - e. P30AI027767
13. Supplement for AMC 084: The Effectiveness of Screening HIV-Infected Women for Anal Cancer Precursors
 - a. National Institute of Health, NCI
 - b. Co-investigator
 - c. Sep 2017 - Aug 2019
 - d. \$193,793
 - e. UM1CA121974

1. National Scientific Participation:

- a. Journal Review editorial boards:
 - a. Ad-hoc journal reviewer, Antiviral Therapy, June 2006-present
 - b. Ad-hoc journal reviewer, Annals Internal Medicine, July 2007-present

- c. Ad-hoc journal reviewer, Clinical Infectious Disease, August 2007-present
- d. Ad-hoc journal reviewer, International Journal of Cancer, July 2011-present
- e. Ad-hoc journal reviewer, International Journal of Infectious Diseases, May 2013-present
- f. Ad-hoc journal reviewer, JAIDS, March 2006-present

- b. Review panels:
 - a. The Ontario HIV Network, grant review July 2006
 - b. Reviewer, Ad Hoc, American Re-investment and Renewal Acct (ARRA) AIDS Cancer Vaccines, NCI, NIH, August, 2009. Bethesda, MD
 - c. Reviewer, Ad Hoc, D43 AIDS Malignancy Training Grants in Africa, NCI, NIH February, 2010. Bethesda, MD
 - d. Reviewer, Ad Hoc, NCI: RFA CA 11-011 and 012 "Research Answers to NCI's Provocative Questions", March 26-28, 2012
 - e. Reviewer, Ad Hoc, NCI: J subcommittee-Career Development Awards, March, 2013
 - f. Reviewer, Ad Hoc, NCI J subcommittee-Career Development Awards, July, 2013
 - g. Reviewer, Ad Hoc, NCI J subcommittee-Career Development Awards, November, 2013
 - h. Reviewer, Ad Hoc, NIAID, HIV and Aging Provocative Questions, November, 2013
 - i. Reviewer, Ad Hoc, NIAID, Special Emphasis Panel, January, 2014
 - j. Reviewer, Ad Hoc, NCI: Subcommittee - HIV and AIDS Malignancy September, 2017
 - k. Reviewer Ad Hoc, NIAID HIV and Aging Special Emphasis Panel, March 2018
 - l. Reviewer, NCI U54 Prevention of HPV-related Cancers in HIV-infected individuals: United States-Latin American-Caribbean Clinical Trials Network: Partnership Centers Special Emphasis Panel, April 2019

- c. Professional societies:
 - i. American Society of Clinical Oncology, 2004-current
 - ii. Infectious Diseases Society of America, 2007-current

- d. National Committees
 - i. ACTG co-infections and malignancies subcommittee 2011-2014
 - ii. ACTG 5298, "A Randomized, Double-Blinded, Placebo-Controlled, Phase 3 Trial of the Quadrivalent HPV Vaccine to Prevent Anal Human Papillomavirus Infection in HIV-Infected Men and Women"
 - iii. NCI "Provocative Questions: AIDS Malignancy" Committee March, 2014
 - iv. AMC Steering Committee, Member 2016-2018
 - v. Chair, AMC Non-AIDS Defining Cancer Committee (April 2017-present)
 - vi. International Conference of HIV Malignancies (ICMH) meeting organizing committee (2017-current)
 - vii. NCI Board of Scientific Advisers, HIV Malignancies, June 2017
 - viii. Scientific Steering Committee of University of Washington /Fred Hutchinson CFAR, March 2018
 - ix. 2018 Eurogin Program Committee, March 2018
 - x. External Advisory Board Weil/Cornell CFAR, February 2019

- e. Invited lectures, presentations, research seminars:
 - a. *International*
 - i. **Chiao, E.** Head and Neck Cancers in U.S. Veterans Living in HIV, IAS Mexico City 7/23/2019
 - ii. **Chiao, E.** Screening HIV-infected Women for Anal Cancer Precursors, Eurogin, Salzburg, Austria 6/10-6/13/2016
 - iii. **Chiao, E.** Screening People Living with HIV for Anal Cancer, Eurogin, Lisbon, Portugal 12/3-12/15/2018
 - b. *National*
 - 1) **Chiao, E.** Co-Chair: International Conference on HIV-related Malignancies, Outcome Disparities of HIV-associated Malignancies, Bethesda, MD, October 21-22, 2019

- 2) **Chiao, E.** A Multi-Disciplinary Approach to Optimizing and Advancing Cancer Care for People Living with HIV, CFAR Seminar, University of Washington, Seattle WA July 11, 2019
- 3) **Chiao, E.** Co-Chair: International Conference on HIV-related Malignancies, Epidemiology of HIV-associated Malignancies, Bethesda, MD, October 22-24, 2017
- 4) **Chiao, E.** Co-Chair: Conference on Retroviruses and Opportunistic Infections (CROI): HPV-related malignancies, February 28-March 3, 2013, Atlanta, GA
- 5) **Chiao, E.** Chair person: AACR Annual Meeting, HIV Malignancies: Current Dilemmas and Future Directions, March 31-April 4, 2012, Chicago, IL.
- 6) **Chiao, E.** HIV- Related Anal Cancer and Cancer Precursors in the HAART Era, Association of Nurses in AIDS Care yearly meeting, September 26, 2008.

c. *Local*

1. **Chiao, E.** MD Anderson Cancer Center Institutional Grand Rounds: HIV and Malignancies, 5/18/2018
2. **Chiao, E.** Screening HIV-infected Individuals for Anal Cancer Precursors: What is the Evidence. Southern AIDS Education and Training Conference, 2/20/2018
3. **Chiao, E.** Viral and Molecular Oncogenesis Program meeting: "Evidence for screening HIV-infected women for anal cancer precursors", 5/18/2011, 5/15/2016.
4. **Chiao, E.** TSH-HCHD HIV Conference 2017: Anal Cancer and HIV, 4/30/2017.
5. **Chiao, E.** CFAR AIDS Research Forum: Human Papilloma Virus and Cancer in HIV-positive Patients, 8/18/17.

2. Publications

a. Full papers in Peer Review Journals:

I. Published

- 1) Clark E, Royse KE, Dong Y, Chang E, Raychaudhury S, Kramer J, White DL, Chiao E. Stable Incidence and Poor Survival for HIV-Related Burkitt Lymphoma Among the U.S. Veteran Population During the Anti-Retroviral Era. J Acquir Immune Defic Syndr. 2020 Jan 27. doi: 10.1097/QAI.0000000000002303. [Epub ahead of print] PubMed PMID: 31977597.
- 2) Stier EA, Abbasi W, Agyemang AF, Valle Álvarez EA, Chiao EY, Deshmukh AA. Recurrence of Anal High-Grade Squamous Intraepithelial Lesions among Women Living with HIV. J Acquir Immune Defic Syndr. 2020 Jan 16. doi: 10.1097/QAI.0000000000002304. [Epub ahead of print] PubMed PMID: 31977596.
- 3) Nyitray AG, D'Souza G, Stier EA, Clifford G, Chiao EY. The Utility of Digital Anal Rectal Examinations in a Public Health Screening Program for Anal Cancer. J Low Genit Tract Dis. 2020 Jan 16. doi: 10.1097/LGT.0000000000000508. [Epub ahead of print] PubMed PMID: 31972661.
- 4) Sandulache VC, Wilde DC, Sturgis EM, Chiao EY, Sikora AG. A Hidden Epidemic of "Intermediate Risk" Oropharynx Cancer. Laryngoscope Investig Otolaryngol. 2019 Oct 17;4(6):617-623. doi: 10.1002/liv.2.316. eCollection 2019 Dec. Review. PubMed PMID: 31890879; PubMed Central PMCID: PMC6929570.
- 5) Sandulache VC, Lei YL, Heasley LE, Chang M, Amos CI, Sturgis EM, Graboyes E, **Chiao EY**, Rogus-Pulia N, Lewis J, Madabhushi A, Frederick MJ, Sabichi A, Ittmann M, Yarbrough WG, Chung CH, Ferrarotto R, Mai W, Skinner HD, Duvvuri U, Gerngross P, Sikora AG. Innovations in risk-stratification and treatment of Veterans with oropharynx cancer; roadmap of the 2019 Field Based Meeting. Oral Oncol. 2019 Oct 21:104440. doi: 10.1016/j.oraloncology.2019.104440. [Epub ahead of print] PubMed PMID: 31648864.
- 6) White, DL; Oluyomi, A; Royse, K.; Dong, Y, Nguyen, H; Chang, E, Richardson, P; Jiao, L; Garcia, J.; Kramer, JR.; Thrift, A, **Chiao, EY**, Incidence of AIDS-related Kaposi Sarcoma in all 50 United States from 2000 to 2014. JAIDS. 2019 Aug 1;81(4):387-394. doi: 10.1097/QAI.0000000000002050. PMID: 31242141
- 7) Stier, A., Lensing, S., Darragh, M., Deshmukh, A., Einstein, M., Palefsky, J., Jay, N. Berry-Lawhorn, J.M., Wilkin, T., Wiley, D., Barroso, L., Cranston, R., Levine, R., Guiot, H., French, A., Citron, D., Rezaei, M.K., Goldstone, S., **Chiao, E.** Prevalence of and risk factors for anal high-

- grade squamous intraepithelial lesions in women living with HIV. Clin Infect Dis. 2019 Jul 11. pii: ciz408. doi: 10.1093/cid/ciz408. Epub ahead of print. PMID: 31292602
- 8) Kramer J, Hartman C, White DL, Royse K, Richardson P, Thirft A, Raychaudhury S, Desiderio R, Sanchez D, **Chiao E**. Validation of HIV cohort identification using automated clinical data in the Department of Veterans Affairs. HIV Medicine. 2019 May 26. doi: 10.1111/hiv.12757. Epub ahead of print. [PMID: 31131549](#)
 - 9) El-Mallawany N, Kamiyango W, Villier J, Peckham-Gregory E, Scheurer M, McAtee C, Allen C, Kovarik C, Frank D, Eason A, Caro-Vegas C, Chiao E, Schutze G, Ozuah N, Mehta P, Kazembe P, Dittmer D. Kaposi Sarcoma Herpesvirus Inflammatory Cytokine Syndrome (KICS)-like Clinical Presentation in HIV-Infected Children in Malawi. Clin Infect Dis. 2019 Mar 22 pii: ciz250. doi: 10.1093/cid/ciz250. Epub ahead of print. [PMID: 31102440](#).
 - 10) Thrift AP, Kramer JR, Hartman CM, Royse K, Richardson P, Dong Y, Raychaudhury S, Desiderio, R, Sanchez D, Anandasabapathy S, White DL, **Chiao EY**. Risk and Predictors of Esophageal and Stomach Cancers in HIV-infected Veterans: A Matched Cohort Study. J Acquir Immune Defic Syndr. 2019 Mar 29. Epub ahead of print. [PMID: 30939533](#)
 - 11) Harms A, Kansara S, Stach C, Richardson P, Chen G, Lai S, Sikora AG, Parke R, Donovan D, **Chiao E**, Skinner H, Sandulache VC. Swallowing Function in Survivors of Oropharyngeal Cancer Is Associated With Advanced T Classification. Ann Otol Rhinol Laryngol 2019 Mar 27;3489419839091. doi: 10.1177/0003489419839091. Epub ahead of print [PMID:30913911](#)
 - 12) Fokom Domgue J, Messick C, Milbourne A, Guo M, Salcedo MP, Dahlstrom KR, **Chiao EY**, Deshmukh AA, Sturgis EM, Schmeler KM. Prevalence of high-grade anal dysplasia among women with high-grade lower genital tract dysplasia or cancer: Results of a pilot study. Gynecologic Oncology. 2019 Mar 1. Doi: 10.1016/j.ygyno. Epub ahead of print. [PMID: 30827725](#)
 - 13) Kahn JA, Belzer M, Chi X, Lee J, Gaur AH, Mayer K, Martinez J, Futterman DC, Stier EA, Paul ME, **Chiao EY**, Reirden D, Goldstone SE, Ortiz Martinez AP, Cachay ER, Barroso LF, Da Costa M, Wilson CM, Palefsky JM; AIDS Malignancy Consortium and Adolescent Medicine Trials Network for HIV/AIDS Interventions. Pre-vaccination prevalence of anogenital and oral human papillomavirus in young HIV-infected men who have sex with men. Papillomavirus Res. 2019 Jan 15;7:52-61. doi: 10.1016/j.pvr.2019.01.002. Epub ahead of print. [PMID: 30658128](#)
 - 14) Badr, H, Herbert, K, Chhabria, K, Sandulache, V, Bobby R, **Chiao, E**, Wagner, T. Couple-Based Self-Management for Head and Neck Cancer: Results of A Randomized Pilot Trial. Cancer. 2018 Dec 6. doi: 10.1002/cncr.31906. [PMID: 30521075](#)
 - 15) Hicks, JT, Hwang, LY, Barnaiuk ,S, White, M, **Chiao, EY**, Onwuka, N, Ross, MW, Nyitray, AG. Factors associated with self-reported anal cancer screening history in men who have sex with men. Sex Health. 2018 Dec 6. Doi: 10.1071/SH18D39. [PMID: 30517839](#)
 - 16) El-Mallawany,N, Villiera, J, Kamiyango, W, Peckham-Gregory, E, Scheurer, M, Allen,C, McAtee, C, Legarreta, A, Dittmer, D, Kovarik, C, **Chiao, E**, Martin,S, Ozuah,N, Mehta,P, Kazembe, P. Endemic Kaposi Sarcoma in HIV-Negative Children and Adolescents: An Evaluation of Overlapping and Distinct Clinical Features in Comparison with HIV-Related Disease. Infectious Agents and Cancer. Infect Agent Cancer.2018 Nov9; 13:33. doi:10.1186/s1307-018-0207-4. eCollection 2018. [PMID: 30455728](#); [PMCID: PMC6230225](#)
 - 17) Richardson P, Kansara S, Chen G, Sabichi A, Sikora A, Parke R, Donovan D, **Chiao E**, Sandulache V. [Treatment Patterns in Veterans with Laryngeal and Oropharyngeal Cancer and Impact on Survival](#). Laryngoscope Invest Otolaryngol. 2018 Aug 9;3(4):275-282. doi: 10.1002/lio2.170. eCollection 2018 Aug. [PMID: 30186958](#) ; [PMCID: PMC6119785](#)
 - 18) Suk,R, Mahale,P, Sonawane, P, Sikora,A, Chhatwal, J, Schmeler, K, Sigel, K, Cantor, S, **Chiao, E*** , Deshmukh, A*. Trends in risks for second primary cancers associated with index Human Papillomavirus-Associated cancers. JAMA Network Open. 2018;1(5) e181999. doi:10.1001/jamanetworkopen.2018.1999. [PMID: 30646145](#) ; [PMCID: PMC6324459](#)
 - 19) Bender Ignacio R, Lin L, Rajdev L, **Chiao E**. Evolving Paradigms in HIV Malignancies: Review of Ongoing Clinical Trials. *Journal of the National Comprehensive Cancer Network : JNCCN*. 2018;16(8):1018-1026. doi:10.6004/jnccn.2018.7064. [PMID: 30099376](#); [PMCID: PMC6109631](#)
 - 20) Oseso LN, **Chiao EY**, Ignacio RAB. Evaluating Antiretroviral Therapy Initiation in HIV-Associated Malignancy: Is There Enough Evidence to Inform Clinical Guidelines? Send to J Natl Compr Canc Netw. 2018 Aug;16(8);927-932. doi: 10.6004/jnccn.2018.7057. [PMID: 30099368](#) ; [PMCID: PMC6207434](#)

- 21) Chang E, Sabichi AL, Kramer JR, Hartman C, Royse KE, White DL, Patel NR, Richardson P, Yellapragada SV, Garcia JM, **Chiao EY**. Nivolumab Treatment for Cancers in the HIV-infected Population. *J Immunother*. 2018 Jul 16. doi: 10.1097/CJI.0000000000000240. [Epub ahead of print] [PMID: 30020193](#) ; [PMCID: PMC6128753](#)
- 22) Chang E, Mapakshi SR, Mbang P, El-Mallawany NK, Kramer JR, White DL, **Chiao EY**. The impact of protease inhibitors on HIV-associated Kaposi sarcoma incidence: a systematic review. *J Acquir Immune Defic Syndr*. 2018 Jul 6. doi: 10.1097/CJI.0000000000000240 [Epub ahead of print.] [PMID: 29985803](#)
- 23) Deshmukh AA, Shirvani SM, Likhacheva A, Chhatwal J, **Chiao EY**, Sonawane K. The Association Between Dietary Quality and Overall and Cancer-Specific Mortality Among Cancer Survivors, NHANES III. *JNCI Cancer Spectr*. 2018 Apr;2(2):pky022. doi: 10.1093/jncics/pky022. Epub 2018 Jun 5. [PMID: 29905226](#) ; [PMCID: PMC5989369](#)
- 24) Thrift AP, **Chiao EY**. Are Non-HIV Malignancies Increased in the HIV-Infected Population? *Curr Infect Dis Rep*. 2018 May 26;20(8):22. doi: 10.1007/s11908-018-0626-9. Review. [PMID: 29804238](#)
- 25) Wilkin TJ, Chen H, Cespedes MS, Leon-Cruz JT, Godfrey C, **Chiao EY**, Bastow B, Webster-Cyriaque J, Feng Q, Dragavon J, Coombs RW, Presti RM, Saah A, Cranston RD. A randomized, placebo-controlled trial of the quadrivalent HPV vaccine in HIV-infected adults age 27 or older: AIDS Clinical Trials Group protocol A5298. *Clin Infect Dis*. 2018 Apr 5. doi: 10.1093/cid/ciy274. [Epub ahead of print] [PMID: 29659751](#) ; [PMCID: PMC6186857](#)
- 26) Cranston RD, Cespedes MS, Paczuski P, Yang M, Coombs RW, Dragavon J, Saah A, Godfrey C, Webster-Cyriaque JY, **Chiao EY**, Bastow B, Wilkin T; ACTG 5298 Study Team. High Baseline Anal Human Papillomavirus and Abnormal Anal Cytology in a Phase 3 Trial of the Quadrivalent Human Papillomavirus Vaccine in Human Immunodeficiency Virus-Infected Individuals Older Than 26 Years: ACTG 5298. *Sex Transm Dis*. 2018 Apr;45(4):266-271. doi: 10.1097/OLQ.0000000000000745. [PMID: 29528986](#); [PMCID: PMC5868482](#)
- 27) Hwang JP, Ahmed S, Ariza-Heredia EJ, Duan Z, Zhao H, Schmeler KM, Ramondetta L, Parker SL, Suarez-Almazor ME, Ferrajoli A, Shih YT, Giordano SH, **Chiao EY**. Low rate of cervical cancer screening among women with hematologic malignancies after stem cell transplant. *Biol Blood Marrow Transplant*. 2018 May;24(5):1094-1098. doi: 10.1016/j.bbmt.2018.01.019. Epub 2018 Feb 9. [PMID: 29378304](#)
- 28) Chang E, Rivero G, Patel N, **Chiao E**, Lai S, Bajaj K, Mbue J, Yellapragada S. HIV-Related Refractory Hodgkin Lymphoma: A Case Report of Complete Response to Nivolumab. *Clin Lymphoma Myeloma Leuk*. 2018 Feb;18(2):e143-e146. doi: 10.1016/j.clml.2017.12.008. Epub 2018 Jan 3. [PMID: 29342442](#); [PMCID: PMC5809264](#)
- 29) Stier EA, **Chiao EY**. Anal Cancer and Anal Cancer precursors in Women with a History of HPV-Related Dysplasia and Cancer. *Semin Colon Rectal Surg*. 2017 Jun;28(2):97-101. doi: 10.1053/j.scrs.2017.04.008. Epub 2017 Apr 26. [PMID:29204065](#) ; [PMCID: PMC5710808](#)
- 30) Sonawane K, Suk R, **Chiao EY**, Chhatwal J, Qiu P, Wilkin T, Nyitray AG, Sikora AG, Deshmukh AA. Oral Human Papillomavirus Infection: Differences in Prevalence Between Sexes and Concordance with Genital Human Papillomavirus Infection, NHANES 2011 to 2014. *Ann Intern Med*. 2017 Nov 21;167(10):714-724. doi: 10.7326/M17-1363. Epub 2017 Oct 17 [PMID:29049523](#) ; [PMCID: PMC6203692](#)
- 31) Deshmukh AA, **Chiao EY**, Cantor SB, Stier EA, Goldstone SE, Nyitray AG, Wilkin T, Wang X, Chhatwal J. Management of precancerous anal intraepithelial lesions in HIV-positive MSM: clinical and cost-effectiveness. *Cancer*. 2017 Dec 1;123(23):4709-4719. doi: 10.1002/cncr.31035. Epub 2017 Sep 26. [Available on 2018-12-01] [PMID: 28950043](#) ; [PMCID: PMC5693634](#)
- 32) Biggerstaff KS, Frankfort BJ, Orengo-Nania S, Garcia J, **Chiao E**, Kramer JR, White D. Validity of code based algorithms to identify primary open angle glaucoma (POAG) in Veterans Affairs (VA) administrative databases. *Ophthalmic Epidemiol*. 2018 Apr;25(2):162-168. doi: 10.1080/09286586.2017.1378688. Epub 2017 Sep 25. [PMID: 28945495](#)
- 33) Nyitray AG, Hicks JT, Hwang L-Y, Baraniuk S, White M, Millas S, Onwuka N, Zhang X, Brown EL, Ross MW, **Chiao EY**. A Phase II clinical study to assess the feasibility of self- and partner anal exams to detect anal canal abnormalities including anal cancer. *Sex Transm Infect*. 2018 Mar;94(2):124-130. doi: 10.1136/sextrans-2017-053283. Epub 2017 Aug 23. [PMID: 28835533](#); [PMCID: PMC6173609](#)

- 34) Royse KE, El Chaer F, Amirian ES, Hartman C, Krown SE, Uldrick TS, Lee JY, Shepard Z, **Chiao EY**. Disparities in Kaposi Sarcoma Incidence and Survival in the United States: 2000-2013. *PLoS One*. 2017 Aug 22;12(8):e0182750. doi: 10.1371/journal.pone.0182750. eCollection 2017. [PMID: 28829790](#); [PMCID: PMC5567503](#)
- 35) Deshmukh AA, Cantor SB, Fenwick E, **Chiao EY**, Nyitray AG, Stier EA, Goldstone SE, Wilkin T, Chhatwal J. Adjuvant HPV vaccination for anal cancer prevention in HIV-positive men who have sex with men: The time is now. *Vaccine*. 2017 Sep 12;35(38):5102-5109. doi: 10.1016/j.vaccine.2017.08.006. Epub 2017 Aug 12. [PMID: 28807605](#); [PMCID: PMC5581672](#) [Available on 2018-09-12]
- 36) Butame SA, Lawler S, Hicks JT, Wilkerson JM, Hwang LY, Baraniuk S, Ross MW, **Chiao EY**, Nyitray AG. (2017). A qualitative investigation among men who have sex with men on the acceptability of performing a self- or partner anal exam to screen for anal cancer. *Cancer Causes Control*. 2017 Oct;28(10):1157-1166. doi: 10.1007/s10552-017-0935-6. Epub 2017 Aug 4. [Available on 2018-10-01]. [PMID: 28779467](#); [PMCID: PMC5731636](#)
- 37) Chew EY, Hartman CM, Richardson PA, Zevallos JP, Sikora AG, Kramer JR, **Chiao EY**. Risk factors for oropharynx cancer in a cohort of HIV-infected veterans. *Oral Oncol*. 2017 May;68:60-66. doi: 10.1016/j.oraloncology.2017.03.004. Epub 2017 Mar 23. [PMID: 28438295](#); [PMCID: PMC6365160](#)
- 38) Kahn JA, Lee J, Belzer M, Palefsky JM, **AIDS Malignancy Consortium and Adolescent Medicine Trials Network for HIV/AIDS Interventions (Chiao EY is listed as a senior author of this group)**. HIV-Infected Young Men Demonstrate Appropriate Risk Perceptions and Beliefs about Safer Sexual Behaviors after Human Papillomavirus Vaccination. *AIDS Behav*. 2017 Feb 20 [Epub ahead of print] PubMed [Available on 2018-08-20] [PMID: 28220313](#); [PMCID: PMC5563486](#)
- 39) Oliver NT, **Chiao EY**. Malignancies in women with HIV infection. *Curr Opin HIV AIDS*. 2017 Jan;12(1):69-76. [PMID: 27849632](#); [PMCID: PMC5568069](#)
- 40) Nyitray A, **Chiao E**. Maybe it isn't time to abandon the digital rectal exam for all conditions. *Curr Med Res Opin*. 2017 Feb;33(2):315-316. doi: 10.1080/03007995.2016.1254608. Epub 2016 Dec 8. [PMID: 27805418](#)
- 41) Deshmukh AA, Zhao H, Das P, **Chiao EY**, You YN, Franzini L, Lairson DR, Swartz MD, Giordano SH, Cantor SB. Clinical and economic evaluation of treatment strategies for T1N0 anal canal cancer. *Am J Clin Oncol*. 2016 Oct 17. [Epub ahead of print]. [PMID: 27755059](#); [PMCID: PMC5393969](#)
- 42) Oliver, NT, Hartman, CM, Kramer, JR, **Chiao, EY**. Statin drugs decrease progression to cirrhosis in HIV/hepatitis C virus coinfecting individuals. *AIDS*. 2016 Oct 23;30(16):2469-2476. [PMID:27753678](#); [PMCID: PMC5290260](#);
- 43) [Lai S, Wenaas AE, Sandulache VC, Hartman C, Chiao E, Kramer J, Zevallos JP](#). Prognostic Significance of p16 Cellular Localization in Oropharyngeal Squamous Cell Carcinoma. *Ann Clin Lab Sci*. 2016 Mar;46(2):132-9. [PMID:27098618](#)
- 44) Varier I, Keeley BR, Krupar R, Patsias A, Dong J, Gupta N, Parasher AK, Genden E, Miles B, Teng M, Bakst RL, Gupta V, Misiukiewicz K, **Chiao E**, Scheurer M, Laban S, Zhang DY, Ye F, Cui M, Demicco EG, Posner MR, Sikora A. Clinical Characteristics and Outcomes of Oropharyngeal Carcinoma Related to High Risk Non-HPV16 Viral Subtypes. *Head Neck*. 2016 Sep;38(9):1330-7. doi: 10.1002/hed.24442. Epub 2016 Apr 15. [PMID:27080140](#)
- 45) Mbang PA, Kowalkowski MA, Amirian ES, Giordano TP, Richardson PA, Hartman CM, **Chiao EY**. Association between Time on Protease inhibitors and the Incidence of Squamous Cell Carcinoma of the Anus among U.S. Male Veterans. *PLoS One*. 2015 Dec 2;10(12):e0142966. doi: 10.1371/journal.pone.0142966. [PMID:26629701](#); [PMCID:PMC4668039](#)
- 46) Deshmukh AA, Zhao H, Franzini L, Lairson DR, **Chiao EY**, Swartz MD, Das P, Giordano SH, Cantor SB. Total Lifetime and Cancer-related Costs for Elderly Patients Diagnosed with Anal Cancer in the United States. *Am J Clin Oncol*. 2015 Oct 29. [Epub ahead of print] [PMID:26523440](#) ; [PMCID: PMC5592145](#);
- 47) **Chiao E**, Stier EA. Reply. *Am J Obstet Gynecol*. 2016 Mar;214(3):411-2. doi: 10.1016/j.ajog.2015.10.917. Epub 2015 Oct 30. [PMID: 26522860](#)
- 48) Battaglia TA, Gunn CM, McCoy ME, Mu HH, Baranoski AS, **Chiao EY**, Kachnic LA, Stier EA. Beliefs About Anal Cancer among HIV-Infected Women: Barriers and Motivators to Participation

- in Research. Womens Health Issues. 2015 Nov-Dec;25(6) :720-6. doi:10.1016/j.whi.2015.06.008. Epub 2015 Aug 4. [PMID:26253825](#); [PMCID:PMC4641840](#)
- 49) Hwang JP, Granwehr BP, Torres HA, Suarez-Almazor ME, Giordano TP, Barbo AG, Lin HY, Fish MJ, **Chiao EY**. HIV testing in patients with cancer at the initiation of therapy at a large US comprehensive cancer center. J Oncol Pract. 2015 Sep;11(5):384-90. doi: 10.1200/JOP.2015.005116. Epub 2015 Aug 4. [PMID:26243649](#) ; [PMCID:PMC4575402](#)
 - 50) Deshmukh AA, Chhatwal J, **Chiao EY**, Nyitray A, Das P, Cantor SB. Long-term outcomes of adding HPV vaccine to the anal intraepithelial neoplasia treatment regimen in HIV-positive men who have sex with men. Clin Infect Dis. 2015 Jul 29. pii: civ628. [PMID:26223993](#); [PMCID:PMC4614412](#)
 - 51) Robinson JO, Slashinski MJ, **Chiao E**, McGuire AL. It depends whose data are being shared; considerations for genomic data sharing policies. J Law Biosci. 2015 jul 21;2(3):697-704. doi: 10.1093/jlb/lsv030. eCollection 2015 Nov. [PMID: 27774218](#) ; [PMCID: PMC5034404](#);
 - 52) Moscicki A, Darragh TM, Berry-Lawhorn JM, Roberts JM, Khan MJ, Boardman LA, **Chiao E**, Einstein MH, Goldstone SE, Jay N, Likes WM, Stier EA, Welton ML, Wiley DJ, Palefsky JM. Screening for Anal Cancer in Women. J Low Genit Tract Dis. 2015 Jul;19(3 Suppl 1):S26-41. doi:10.1097/LGT.0000000000000117. [PMID:26103446](#); [PMCID:PMC4479419](#)
 - 53) Stier EA, Sebring MC, Mendez AE, Ba FS, Trimble DD, **Chiao EY**. Prevalence of anal human papillomavirus infection and anal HPV-related disorders in women: a systematic review. Am J Obstet Gynecol. 2015 Sep;213(3):278-309. doi: 10.1016/j.ajog.2015.03.034. Epub 2015 Mar 19. [PMID:25797230](#); [PMCID:PMC4556545](#)
 - 54) Kowalkowski MA, Kramer JR, Richardson PR, Suteria I, **Chiao EY**. Use of boosted protease inhibitors reduces Kaposi sarcoma incidence among male veterans with HIV Infection. Clin Infect Dis. 2015 May 1;60(9):1405-14. doi:10.1093/cid/civ012. Epub 2015 Jan 13. [PMID:25586682](#); [PMCID:PMC4462659](#)
 - 55) Kim MH, Ahmed S, Hosseinipour MC, Giordano TP, **Chiao EY**, Yu X, Nguyen C, Chimbwandira F, Kazembe PN, Abrams EJ. Implementation and operational research: The impact of Option B+ on the antenatal PMTCT cascade in Lilongwe, Malawi. J Acquir Immune Defic Syndr. 2015 Apr 15;68(5):e77-83. doi:10.1097/QAI.0000000000000517. [PMID:25585302](#); [PMCID:PMC4359035](#)
 - 56) Ahmed S, Kim M, Dave A, Sabelli R, Kanjelo K, Preidis G, Giordano TP, **Chiao EY**, Hoessinipour M, Kazembe P, Chimbwandira F, Abrams E. Improved identification and enrollment into care of HIV-exposed and infected infants and children following a community health worker intervention in Lilongwe, Malawi. J Int AIDS Soc. 2015 Jan 7;18(1):19305. doi:10.7448/IAS.18.1.19305. eCollection 2015. [PMID: 25571857](#); [PMCID:PMC4287633](#)
 - 57) Kramer JR, Kowalkowski MA, Duan Z, **Chiao EY**. The Effect of HIV Viral Control on the Incidence of Hepatocellular Carcinoma in Veterans with Hepatitis C and HIV Coinfection. J Acquir Immune Defic Syndr. 2015 Apr 1;68(4):456-62. doi:10.1097/QAI.0000000000000494. [PMID:25559606](#); [PMCID:PMC4334674](#)
 - 58) Dailey Garnes NJ, D'Souza G, **Chiao E**. Number of Primary Care Visits Associated with Screening for Cervical Dysplasia among Women with HIV Infection in Harris County, Texas, United States of America. HIV Adv Res Dev. 2015;1(2). pii: 107. Epub 2015 Feb 16. [PMID:27500276](#); [PMCID:PMC4974513](#)
 - 59) Deshmukh AA, **Chiao EY**, Das P, Cantor SB. Clinical effectiveness and cost-effectiveness of quadrivalent human papillomavirus vaccination in HIV-negative men who have sex with men to prevent recurrent high-grade anal intraepithelial neoplasia. Vaccine. 2014 Nov;32(51):6941-6947 doi:10.1016/j.vaccine.2014.10.052. [PMID:25444820](#); [PMCID:PMC4254641](#)
 - 60) Zevallos JP, Hartman CM, Kramer JR, Strugis EM, **Chiao EY**. Increased Thyroid Cancer Incidence Corresponds to Increased Utilization of Thyroid Ultrasound and Fine Needle Aspiration: A Population-based Study in the Veterans Affairs Healthcare System. [Cancer](#). 2014 Nov 6. doi: 10.1002/cncr.29122. [PMID:25376872](#)
 - 61) Luu HN, Amirian ES, **Chiao EY**, Scheurer ME. Age patterns of Kaposi's sarcoma incidence in a cohort of HIV-infected men. Cancer Med. 2014 Aug 20. doi: 10.1002/cam4.312. [PMID:25139791](#); [PMCID:PMC4298390](#)
 - 62) Kowalkowski M, Day R, Du X, Chan W, **Chiao E**. Cumulative HIV Viremia and Non-AIDS-Defining Malignancies Among a Sample of HIV-Infected Male Veterans. J Acquir Immune Defic Syndr. 2014 Jul 30. [PMID:25078536](#); [PMCID:PMC4162758](#)

- 63) Zevallos JP, Sandulache VC, Hamblin J, Skinner HD, Kramer J, Hartman CM, Horter KL, Lai S, Zhou X, **Chiao EY**. The impact of race on oropharyngeal squamous cell carcinoma presentation and outcomes among veterans. *Head Neck*. 2016 Jan;38(1):44-50. doi: 10.1002/hed.23836. Epub 2015 Jan 27. [PMID:24992520](#)
- 64) Kowalkowski MA, Mims MA, Day RS, Du XL, Chan W, **Chiao EY**. Longer duration of combination antiretroviral therapy reduces the risk of Hodgkin lymphoma: A cohort study of HIV-infected male veterans. *Cancer Epidemiol*. 2014 Aug;38(4):386-92. doi: 10.1016/j.canep.2014.05.009. Epub 2014 Jun 16. [PMID:24947588](#); [PMCID:PMC4447432](#)
- 65) Sandulache VC, Hamblin J, Lai S, Pezzi T, Skinner HD, Khan NA, Dioun SM, Hartman C, Kramer J, **Chiao E**, Zhou X, Zevallos JP. Oropharyngeal squamous cell carcinoma (OPSCCA) in the veteran population is associated with traditional carcinogen exposure and poor clinical outcomes. *Head Neck*. 2014 May 7; [PMID:24801106](#); [PMCID:PMC4496314](#)
- 66) Dinardo AR, Lewis DS, Koo HL, Goodman JC, **Chiao E**, Andrade R. Paradoxical immune reconstitution inflammatory syndrome due to toxoplasmic encephalitis: two cases and review of initiation of antiretroviral timing in toxoplasmic encephalitis IRIS. *F1000Res*. 2013 May 30;2. doi: 10.12688/f1000research.2-133. [PMID:24358883](#); [PMCID:PMC3814919](#)
- 67) Valentin L, Dinardo A, **Chiao E**, Woc-Colburn L, Nachiappan A. Tuberculosis IRIS a mediastinal problem. *F1000Res*. 2013 Feb 18;2. doi: 10.12688/f1000research.2-54 [PMID:24358876](#); [PMCID:PMC3799548](#)
- 68) Kowalkowski MA, Lulla P, Mims MP, Amirian ES, **Chiao EY**. Effect of Immune Reconstitution on the Incidence of HIV-Related Hodgkin Lymphoma. *PLoS One*. 2013 Oct 2;8(10):e77409. doi: 10.1371/journal.pone.0077409. [PMID:24098586](#) ; [PMCID:PMC3788758](#)
- 69) Kim MH, Ahmed S, Preidis GA, Abrams EJ, Hosseinipour MC, Giordano TP, **Chiao EY**, Paul ME, Bhalakia A, Nanthuru D, Kazembe PN. Low Rates of Mother-to-Child HIV Transmission in a Routine Programmatic Setting in Lilongwe, Malawi. *PLoS One*. 2013 May 31;8(5):e64979. [PMID:23741437](#); [PMCID:PMC3669205](#)
- 70) Amirian ES, **Chiao EY**, Hill KT, Marquez-Do D, Scheurer ME. Preliminary findings from a pilot study on the effects of interferon- α treatment on human papillomavirus infection in HIV and hepatitis C virus co-infected men. *Sexual health*. 2013 November 22; 10(6):570-570 <https://doi.org/10.1071/SHv10n6ab2>
- 71) **Chiao EY**, Hartman CM, El-Serag HB , Giordano TP. The Impact of HIV Viral Control on the Incidence of HIV-Associated Anal Cancer. 2013 Apr 22 *JAIDS* [PMID:23614995](#); [PMCID:PMC3797186](#)
- 72) Amirian ES, Fickey PA Jr, Scheurer ME, **Chiao EY**. Anal Cancer Incidence and Survival: Comparing the Greater San-Francisco Bay Area to Other SEER Cancer Registries. *PLoS One*. 2013;8(3):e58919. doi: 10.1371/journal.pone.0058919. [PMID:23484057](#); [PMCID:PMC3590168](#)
- 73) Betancourt EM, Wahbah MM, Been LC, **Chiao EY**, Citron DR, Laucirica R. Anal cytology as a predictor of anal intraepithelial neoplasia in HIV-positive men and women. *Diagn Cytopathol*. 2013 Jan 3. doi: 10.1002/dc.22941. [PMID:23288861](#)
- 74) Kim M, Ahmed S, Buck W, Preidis G, Hosseinipour M, Bhalakia A, Nanthuru D, Kazembe P, Chimbwandira F, Giordano T, **Chiao E**, Schutze G, Kline M, The Tingathe program: a pilot intervention using community health workers to create a continuum of care in the Prevention of Mother to Child Transmission of HIV (PMTCT) cascade of services in Malawi, *Journal International AIDS Society*. 2012 Jul 11;15(4):1-11 [PMID:22789644](#); [PMCID:PMC3499848](#)
- 75) **Chiao EY**, Nambi PV, Naik AD. The impact of diabetes process and outcome quality measures on overall survival in patients with co-morbid colorectal cancer. *J Cancer Surviv*. 2010 Dec;4(4):381-7. [PMID:20721633](#); [PMCID:PMC3175493](#)
- 76) **Chiao EY**, Dezube BJ, Krown SE, Wachsman W, Brock MV, Giordano TP, Mitsuyasu R, Pantanowitz L. Time for oncologists to opt in for routine opt-out HIV testing? *JAMA*. 2010 Jul 21;304(3):334-9. [PMID:20639567](#); [PMCID:PMC3160789](#)
- 77) **Chiao EY**, Engels EA, Kramer JR, Pietz K, Henderson L, Giordano TP, Landgren O. Risk of immune thrombocytopenic purpura and autoimmune hemolytic anemia among 120 908 US veterans with hepatitis C virus infection. *Arch Intern Med*. 2009 Feb 23;169(4):357-63. [PMID:19237719](#); [PMCID:PMC2782638](#)

- 78) **Chiao EY**. Duration of anal human papilloma virus infection among immunocompetent women: clues to anal cancer epidemiology and possible prevention strategies. [Clin Infect Dis](#). 2009 Mar 1;48(5):547-9. [PMID:19191637](#)
- 79) El-Serag HB, Engels EA, Landgren O, **Chiao E**, Henderson L, Amaratunge HC, Giordano TP. Risk of hepatobiliary and pancreatic cancers after hepatitis C virus infection: A population-based study of U.S. veterans. [Hepatology](#). 2009 Jan;49(1):116-23. [PMID:19085911](#); [PMCID:PMC2719902](#)
- 80) Davila JA, **Chiao EY**, Hasche JC, Petersen NJ, McGlynn KA, Shaib YH. Utilization and determinants of adjuvant therapy among older patients who receive curative surgery for pancreatic cancer. [Pancreas](#). 2009 Jan;38(1):e18-25. [PMID:18797424](#); [PMCID:PMC3835699](#)
- 81) **Chiao EY**, Giordano TP, Richardson P, El-Serag HB. Human immunodeficiency virus-associated squamous cell cancer of the anus: epidemiology and outcomes in the highly active antiretroviral therapy era. [J Clin Oncol](#). 2008 Jan 20;26(3):474-9. [PMID:18202423](#)
- 82) Arora A, **Chiao E**, Tying SK. AIDS malignancies. [Cancer Treat Res](#). 2007;133:21-67. [PMID:17672037](#)
- 83) Giordano TP, Henderson L, Landgren O, **Chiao EY**, Kramer JR, El-Serag H, Engels EA. Risk of non-Hodgkin lymphoma and lymphoproliferative precursor diseases in US veterans with hepatitis C virus. [JAMA](#). 2007 May 9;297(18):2010-7. [PMID:17488966](#)
- 84) **Chiao EY**, Giordano TP, Palefsky JM, Tying S, El Serag H. Screening HIV-infected individuals for anal cancer precursor lesions: a systematic review. [Clin Infect Dis](#). 2006 Jul 15;43(2):223-33. Review. [PMID:16779751](#)
- 85) **Chiao EY**, Krown SE, Stier EA, Schrag D. A population-based analysis of temporal trends in the incidence of squamous anal canal cancer in relation to the HIV epidemic. [J Acquir Immune Defic Syndr](#). 2005 Dec 1;40(4):451-5. [PMID:16280701](#)
- 86) Fields KS, Petersen MJ, **Chiao E**, Tristani-Firouzi P. Case reports: treatment of nevirapine-associated dress syndrome with intravenous immune globulin (IVIG). [J Drugs Dermatol](#). 2005 Jul-Aug;4(4):510-3. [PMID:16004028](#)
- 87) Stier EA, Krown SE, Chi DS, Brown CL, **Chiao EY**, Lin O. Anal dysplasia in HIV-infected women with cervical and vulvar dysplasia. [J Low Genit Tract Dis](#). 2004 Oct;8(4):272-5. [PMID:15874871](#)
- 88) Teruya-Feldstein J, **Chiao E**, Filippa DA, Lin O, Comenzo R, Coleman M, Portlock C, Noy A. CD20-negative large-cell lymphoma with plasmablastic features: a clinically heterogeneous spectrum in both HIV-positive and -negative patients. [Ann Oncol](#). 2004 Nov;15(11):1673-9. [PMID:15520070](#)
- 89) **Chiao EY**, Krown SE. Update on non-acquired immunodeficiency syndrome-defining malignancies. [Curr Opin Oncol](#). 2003 Sep;15(5):389-97. [PMID:12960522](#)
- 90) **Chiao EY**, Ries KM, Sande MA. AIDS and the elderly. [Clin Infect Dis](#). 1999 Apr;28(4):740-5. [PMID:10825030](#)
- 91) **Chiao E**, Hadler J. From the Centers for Disease Control. Early childhood vaccination levels. [JAMA](#). 1992 Feb 5;267(5):628-9NB. As reported from: CDC. Early Childhood Vaccination Levels Among Urban Children in Connecticut 1990 and 1991. [MMWR RR2](#); 40: 888-90.1991. [PMID:1731124](#)

II. In Press

1. Gutierrez AM, Hofstetter JD, Dishner E, **Chiao EY**, Rai D, McGuire AL. A right to privacy and confidentiality: Ethical medical care for patients in United States immigration detention. [Journal of Law, Medicine, and Ethics](#); Spring 2020

2. Sandulache VC, Wilde DC, Sturgis, **Chiao EY**, Sikora AG. A Hidden Epidemic of "Intermediate Risk" Oropharynx Cancer. [Laryngoscope Investigative Otolaryngology](#).

III. Submitted/Under Review

1. Suk R, Montealegre J, Nemutlu G, Nyitray A, Chhatwal J, Bauer C, Chiao E, Schmeler K, Sonawane K, Deshmukh A. Knowledge of Human Papillomavirus (HPV), HPV Vaccine, and HPV-associated Cancers: Sex Differences in the United States, HINTS-5. [JAMA IM](#).

b. Abstracts given during last three years:

- 1) **Elizabeth Chiao**, MD, MPH, Dorothy J. Wiley PhD, Shelly Y Lensing, MS, Teresa Darragh, MD, Mark H Einstein, MD, Naomi Jay, PhD, J. Michael Berry Lawhorn, MD, Ashish A Deshmukh, PhD, Joel M Palefsky, MD, Timothy Wilkin, MD, Luis F Barroso, MD, Rebecca Levine, MD, Audrey L French, MD, Humberto Guiot MD, Ross D Cranston, MD, Elizabeth Stier, MD. Screening Tests for Anal High-Grade Squamous Intraepithelial Lesion Detection in Women Living with HIV. Poster presented at 17th International Conference on Malignancies in HIV/AIDS (ICMH), Bethesda, MD, October 21-22, 2019.
- 2) Eva Clark, Liang Chen, Yongquan Dong, Suchismita Raychaudhury, Jennifer Kramer, Donna White, **Elizabeth Chiao**. HIV+ Female Veterans Are At Increased Risk of Developing Genital Cancers. Poster presented at 17th International Conference on Malignancies in HIV/AIDS (ICMH), Bethesda, MD, October 21-22, 2019.
- 3) Eva Clark MD, Kathryn E. Royse, Yongquan Dong, Elaine Chang, Suchismita Raychaudhury, Jennifer Kramer, Donna White, **Elizabeth Chiao**. Burkitt Lymphoma in The ART Era: Stable Incidence, Poor Survival. Poster presented at 17th International Conference on Malignancies in HIV/AIDS (ICMH), Bethesda, MD, October 21-22, 2019.
- 4) Kathryn E. Royse, Jose M. Garcia, Donna L. White, Jennifer R. Kramer, Yongquan Dong, Suchismita Raychaudhury, Peter A. Richardson, Christine Hartman, **Elizabeth Y. Chiao**. Prostate adenocarcinoma incidence and risk factors in Veterans with well controlled HIV infection. In: Proceedings of the American Association for Cancer Research Annual Meeting 2019, March 29- Apr 3; Atlanta, GA. Philadelphia
- 5) Domgue JF, Messick C, Milbourne A, Guo M, Salcedo M, **Chiao E**, Dahlstrom K, Sturgis E, Schmeler K. Prevalence of anal dysplasia and cancer in women with lower genital tract dysplasia and cancer: Preliminary results of the PANDA Study. Accepted for presentation at the 17th Biennial Meeting of the International Gynecologic Cancer Society. Kyoto, Japan. September 14-16, 2018.
- 6) Mapakshi S, Kramer JR, Royse K, **Chiao E**, Garcia J, Kanwal F, El-Serag HB, Jiao L, White DL. Statins Use and Overall Survival in Pancreatic Cancer Patients: A Systematic Review and Meta-analysis. Accepted for presentation at the annual Digestive Disease Week 2018. Washington, DC. June 2-5, 2018.
- 7) Chang E, Thrift AP, White DL, Kramer J, Sabichi AL, Hartman C, Royse KE, Richardson P, **Chiao EY**. Nivolumab efficacy and safety in veterans with and without HIV infection. Accepted for presentation at the annual American Association for Cancer Research 2018. Chicago, Illinois. April 14-18, 2018.
- 8) Garcia JM, Kramer JR, Richardson PA, White D, Raychaudhury S, Chang E, Hartman C, **Chiao EY**. Effect of Diabetes, Metabolic factors and Medications on Risk of Lung Cancer among HIV-Infected Veterans. Accepted for presentation at the annual Endocrine Society 2018. Chicago, Illinois. March 17-20, 2018.
- 9) Thrift AP, Royse KE, Richardson PA, Raychaudhury S, Desiderio R, White DL, Kramer JR, **Chiao E**. Risk of Non-AIDS-Defining Cancers among Veterans with well-controlled HIV Infection. Accepted for presentation at the Conference on Retroviruses and Opportunistic Infections, Boston, MA, March 4-8, 2018.
- 10) Thrift AP, White DL, Nguyen HP, Royse KE, Kramer JR, **Chiao EY**. Trends in incidence of Kaposi Sarcoma among males in all 50 United States between 2000 and 2013. Accepted for presentation at the Conference on Retroviruses and Opportunistic Infections, Boston, MA, March 4-8, 2018.
- 11) Mapakshi S, Mbang P, Kramer JR, White DL, **Chiao EY**. Impact of Protease Inhibitor Based Regimens on Incidence of HIV associated Kaposi Sarcoma: A Systematic Review of Literature.

Presented at the International Conference on Malignancies in HIV/AIDS. Bethesda, MD. October 23-24, 2017

- 12) Thrift AP, Royse KE, Richardson PA, Raychaudhury S, Desiderio R, White DL, Kramer JR, **Chiao EY**. Risk Of Non-AIDS-Defining Cancers Among Veterans With Well-Controlled HIV Infection. Presented at the International Conference on Malignancies in HIV/AIDS. Bethesda, MD. October 23-24, 2017
 - 13) Chang E, Hartman C, Royse K, Kramer J, White D, Richardson P, **Chiao EY**. A Case Series of Nivolumab in Veterans with HIV Infection and Malignancy. Presented at the International Conference on Malignancies in HIV/AIDS. Bethesda, MD. October 23-24, 2017
 - 14) Mapakshi SR, Kramer JR, Royse KE, **Chiao E**, Garcia JM, Kanwal F, El-Serag H, Jiao L, White D. Statins Use and Overall Survival in Pancreatic Cancer Patients: A Systematic Review and Meta-analysis. Presented at the annual Digestive Disease Week Meeting, Chicago, Illinois, May 6, 2017.
 - 15) Biggerstaff K, Kramer J, **Chiao E**, Richardson P, Orengo-Nania S, Frankfort B, White D. Open Angle Glaucoma (OAG) and Uric Acid (UA) Levels in the Veteran Population. Presented at the 27th Annual Meeting of the American Glaucoma Society, Coronado, California. March 3, 2017.
 - 16) Biggerstaff K, Frankfort B, Orengo-Nania S, Garcia J, **Chiao E**, Kramer J, White D. Diagnostic Algorithms to Identify Primary Open Angle Glaucoma in Veterans Affairs Administrative Databases. Poster presented at 2016 Michael E. DeBakey VA Medical Center Research Poster Day, Houston, Texas, October 26, 2016.
 - 17) Biggerstaff K, Frankfort B, Orengo-Nania S, Garcia J, **Chiao E**, Kramer J, White D. Diagnostic Algorithms to Identify Primary Open Angle Glaucoma in Veterans Affairs Administrative Databases. Poster presented at 2016 Baylor Graduate Student Symposium, Houston, Texas, October 19, 2016.
 - 18) Varier I, Chew E, Ramsey D, Sikora A, **Chiao E**. HEALTHCARE UTILIZATION IN HPV - RELATED CANCERS. Presented at the AHNS 9th International Conference on Head and Neck Cancer, Seattle, WA, July 18, 2016.
 - 19) Wilkin TJ, Chen H, Cespedes M, Paczuski P, Godfrey C, **Chiao E**, Luque A, Webster-Cyriaque JY, Bastow B, Cranston R. ACTG A5298: A Phase 3 Trial of the Quadrivalent HPV Vaccine in Older HIV+ Adults. CROI February 23, 2016.
 - 20) Oliver N, Hartman CM, Kramer JR, **Chiao EY**. Statin Use and the Impact on Cirrhosis Progression in a HIV/HCV Co-infected Population. Poster Presented at the Conference on Retroviruses and Opportunistic Infections, Boston, MA, February 23, 2016.
 - 21) Oliver N, Hartman CM, Kramer JR, **Chiao EY**. Metabolic Risk Factors Associated with HCC Development in an HIV/HCV Co-Infected Cohort. Poster Presented at the 15th Conference on Malignancies in AIDS and Other Acquired Immunodeficiencies, Bethesda, MD, October 26, 2015.
- c. Books:
- a. complete books written: N/A
 - b. books edited: N/A
 - c. book chapters written
 - 1) Chang E, **Chiao EY**. Oncologic Manifestations of HIV Infection. In The Sub-Specialty Care of HIV-Infected Patients. Nova Scientific Publications, 2018.
 - 2) Oliver N, **Chiao EY**. Malignant Diseases in HIV. In AAHIVM Fundamentals of HIV Medicine. Oxford University Press. 2017
 - 3) **Chiao E**. Malignant Diseases in HIV. In Looking for Daylight: Evidence in Medicine and Federal Policy on Comparative Effectiveness Research. Oxford University Press, 2016

- 4) Mbang P, **Chiao E**. Malignancies and Neoplasms. In AAHIMV Fundamentals of HIV Medicine. AAHIVM, 2012
- 5) Tarakaji M, **Chiao E**. Anal Canal Carcinoma. In Tumor Board Reviews, Guidelines and Case Reviews in Oncology, Demos Medical. 2012
- 6) **Chiao. E**. Epidemiology and Clinical Characteristics of Non-AIDS-Defining Malignancies in Molecular basis for therapy of AIDS defining cancers, Springer 2010
- 7) **Chiao EY**, Krown SE. Non-AIDS-Defining Cancers in HIV Infected Individuals. In, Viral and Immunological Malignancies. PA Volberding and J Palefsky, eds. American Cancer Society, Atlas of Clinical Oncology. 2006
- 8) Arora A, **Chiao E**, Tying S. Treatment of AIDS-Associated Viral Oncogenesis. In AIDS Associated Viral Oncogenesis. Myers, C editor. Springer publishing, 2007.
- d. Other works communicating research results to scientific colleagues: N/A
- e. Other works communicating research results to general public : N/A

III. TEACHING INFORMATION

A. Educational Leadership Roles

1. CSTP research mentor,
2. T32 research mentor, Infectious Disease T32, medical oncology T32

B. Didactic course work

1. Courses taught at current institution:
 - a. Implicit Association Test (IAT) "Best Intentions" Workshop for the LACE course 2009-present
 - b. Patient Safety Course Steering Committee, 2011-2012
 - c. Infectious Diseases Course: Viruses and Cancer 2012-2018
2. Courses taught at other institutions: N/A
3. Courses expected to be taught at BCM: Undergraduate Medical Education: Infectious Diseases Course

C. Curriculum development work None

D. Non-didactic teaching

1. Resident training: 80 hours
2. Clinical Fellow training: Ben Taub General Hospital 4 weeks per year
3. Graduate Student training: PhD Dissertation Committee: Mark Kowalkowski, PhD September, 2013, Ashish Deshmukh, UTSPH PhD 2014, Hsuan-Chen Liu PhD 2019 (expected)
4. Estimate of kinds of non-didactic teaching expected at BCM: Mentor for internal Medicine Residents and Fellows Research; Dan Haim Cohen 2007-2008, and Natalie Dailey 2009-2010, Virginia Jackson 2011-2012, Pamela Mbang 2015-2016, Nora Oliver, Elaine Chang 2017-2018, Eva Clark 2018-2021
5. Medical School Mentor 2009-2011 Medical Students: Erin Chew 2016-2018, Alison Kremer Yoder 2018-2019
6. Mentor Junior Faculty: Maria Kim, MD; Saeed Ahmed, MD; Jose Zevallos, MD- recipient VISN 16 Pilot; Aaron Thrift, PhD, Michael Scheurer, PhD, Vlad Sandluche, MD/PhD, Bich Dang, MD, Andrew Dinardo, MD (pediatrics), Lillie Lin, MD (MDACC), Ashish Deshmukh, MD (University of Florida), Rachel Bender Ignacio, MD (University of Washington), Alan Nyitray, PHD (University of Texas School of Public Health)

E. Lectures and Presentations:

1. *International*:
 - a. **Chiao, E**. Panelist, Confronting the Challenges Relevant to HIV/AIDS Malignancies in Sub-Saharan Africa Symposium, Capetown, South Africa 7/31-8/2/2015
2. *National*:

- a. **Chiao, E.** Human Immunodeficiency Virus and Cancer: *A Multi-disciplinary Approach to Optimizing and Advancing Clinical Care*. Boston University Infectious Diseases Grand Rounds, March 21, 2019
 - b. **Chiao, E.** HIV in the Southern United States. Symposium: An Interdisciplinary History of the Struggle Against HIV/AIDS. University of Utah Law school, October 2, 2015
 - c. "HIV and the 50 plus population" 2007. AETC. Cornell University Medical College, NY, NY. June 15, 2007
 - d. "Oncology and HIV Disease" 2005. Quarterly Roundtable Discussion. Moderated by Kristen Ries, University of Utah.
3. *Regional:*
- a. The Epidemiology and Outcomes of HPV-Associated Malignancies. Cancer Program Continuing Medical Education, Alexandria, VA, 8/8/13
 - b. "HIV and the over 50 population" 15th Annual Thomas Street HIV Conference. Houston Hyatt. December 16, 2006
 - c. "HIV and the Elderly" West Houston Medical Center. Sponsored by Texas-Oklahoma AIDS Education Training Center. April 8, 2005
4. *Local:* (See FAP Educational Portfolio for additional recurring lectures)
- a. Research in Progress: VA Research Symposium, Michael E. Debakey, January 2018
 - b. Research in Progress: Infectious Diseases Division, Baylor College of Medicine, May 2017
 - c. Citywide Infectious Diseases Conference, Baylor College of Medicine, March 2016
 - d. BCM Grand Rounds: "Infectious Disease Update: HPV vaccine update", January 2012
 - e. BCM Grand Rounds: "CPC: Lumps on the Head", January 2012
 - f. Research in Progress: Infectious Diseases Division, Baylor College of Medicine, February 2008
 - g. CPC Internal Medicine, Baylor College of Medicine March 2007
 - h. "Update on AIDS-Related Malignancies" VA and Thomas Street Clinical Noon Conferences. January, 2006
 - i. Anal Cancer and Anal Cancer Precursors among HIV-Infected Individuals. Quality Research in Progress Seminar Series. Houston Center for Quality Care and Utilization Services (HCQCUS). October 8, 2005

F. Visiting professorships: N/A

IV. MEDICAL AND SERVICE INFORMATION

A. Patient care responsibilities

1. Department-wide: N/A
2. Section or specialty:
 - a. HIV/Infectious Disease Attending: Ben Taub General Hospital
 1. 1.5 months per year, 2006-current
 - b. HIV/Infectious Disease Clinic: Thomas Street Clinic
 1. ½ day every other week, 2006-current
 - c. Medical Oncology Clinic: Thomas Street Clinic
 1. ½ day every other week, plus emergency weekly visits, 2006-current
 - d. Anal Dysplasia Clinic: Thomas Street Clinic
 1. ½ day every week, 2006-current
 - e. Research Clinic (Med Onc and Anal Dysplasia) for AMC trials
 1. ½ day every week 2008-current

B. Clinical Leadership or Business Development: N/A

C. Voluntary Health Organization Participation: N/A

V. SERVICE CONTRIBUTIONS

A. Administrative assignments

1. Department administration, committees, etc:
2. College, School or University administration, committees, etc
 - a. IRB member July 2006- July 2009,
 - b. Baylor Department Medicine Research Committee, January 2018

B. National, Regional or Local Participation in Professional or Voluntary Organizations

1. Hurricane "Harvey" Hero September 2017

A handwritten signature in black ink, appearing to read "Gloria" or similar, with a stylized flourish at the end.

Last updated 12/30/2019

Exhibit 4

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. 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 a novel zoonotic coronavirus 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 March 12, 2020, there are over 140,000 confirmed cases of COVID-19. COVID-19 has caused over 5,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.
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. 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.
7. The COVID-19 virus 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 myocarditis, 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.
8. There is no 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.
9. COVID-19 is known to be spreading in the Seattle, Washington-area community. As of March 11, 2020 there are 270 confirmed cases of COVID-19 (an increase of 36 from March 10, 2020) and twenty-seven deaths from COVID-19 in the Seattle area. This

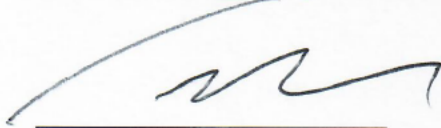
represents the largest known outbreak in the United States, and one the largest known outbreaks in the world as of March 12, 2020.

10. 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.
11. Based on the recovered genomes of the virus from the community analyzed by the Nextstrain project run by Dr. Trevor Bedford of the Fred Hutchinson Cancer Research Center in Seattle, it is known that the infection is being shared from person to person in and around Seattle. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. The strain of virus spreading in the Seattle area is genetically related to the strain of virus that spread readily on the cruise ships.
12. The COVID-19 outbreak in Seattle has resulted in the need for unprecedented public health measures, including multiple efforts to facilitate and enforce social distancing. These include encouraging employees to work from home, bans of gathering of more than 250 people, closure of schools, closure of the University of Washington campus in Seattle, limitations of visitation to skilled nursing facilities, and cancellation of major public events. Individuals have been asked to delay or cancel health care procedures in order to free up capacity within the system.
13. 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, particularly when residents cannot engage in proper hygiene and isolate themselves from infected residents or staff.
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 an immigration detention center, with limited access to adequate hygiene facilities 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 13th day in March, 2020 in Ann Arbor, Michigan.

A handwritten signature in black ink, appearing to read 'Jonathan Golob', is written over a horizontal line.

Dr. Jonathan Louis Golob

Exhibit 5

1 Timothy P. Fox (CA Bar 157750)
2 *tfox@creeclaw.org*
3 Elizabeth Jordan*
4 *ejordan@creeclaw.org*
5 CIVIL RIGHTS EDUCATION AND
6 ENFORCEMENT CENTER
1245 E. Colfax Avenue, Suite 400
Denver, CO 80218
Tel: (303) 757-7901
Fax: (303) 872-9072

7 Lisa Graybill*
8 *lisa.graybill@splcenter.org*
9 Jared Davidson*
10 *jared.davidson@splcenter.org*
11 SOUTHERN POVERTY LAW
12 CENTER
201 St. Charles Avenue, Suite 2000
New Orleans, Louisiana 70170
Tel: (504) 486-8982
Fax: (504) 486-8947

Stuart Seaborn (CA Bar 198590)
sseaborn@dralegal.org
Melissa Riess (CA Bar 295959)
mriess@dralegal.org
DISABILITY RIGHTS ADVOCATES
2001 Center Street, 4th Floor
Berkeley, California 94704
Tel: (510) 665-8644
Fax: (510) 665-8511

13
14
15 Attorneys for Plaintiffs (continued on next page)

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

19 FAOUR ABDALLAH FRAIHAT, *et al.*,
20 Plaintiffs,

21 v.

22 U.S. IMMIGRATION AND CUSTOMS
23 ENFORCEMENT, *et al.*,

24 Defendants.

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

DECLARATION OF
DR. CARLOS FRANCO-PAREDES

Date: March 24, 2020

1 William F. Alderman (CA Bar 47381)
2 *walderman@orrick.com*
3 Jake Routhier (CA Bar 324452)
4 *jrouthier@orrick.com*
5 ORRICK, HERRINGTON &
6 SUTCLIFFE LLP
405 Howard Street
San Francisco, CA 94105
Tel: (415) 773-5700
Fax: (415) 773-5759

7 Michael W. Johnson**
8 *mjohnson1@willkie.com*
9 Dania Bardavid**
10 *dbardavid@willkie.com*
11 Jessica Blanton**
12 *jblanton@willkie.com*
13 Joseph Bretschneider**
14 *jbretschneider@willkie.com*
WILLKIE FARR &
GALLAGHER LLP
787 Seventh Avenue
New York, NY 10019
Tel: (212) 728-8000
Fax: (212) 728-8111

15 Maia Fleischman*
16 *maia.fleischman@splcenter.org*
17 SOUTHERN POVERTY LAW
18 CENTER
2 South Biscayne Boulevard
Suite 3750
Miami, FL 33131
Tel: (786) 347-2056
Fax: (786) 237-2949

20 Christina Brandt-Young*
21 *cbrandt-young@dralegal.org*
22 DISABILITY RIGHTS
23 ADVOCATES
655 Third Avenue, 14th Floor
New York, NY 10017
Tel: (212) 644-8644
Fax: (212) 644-8636

Mark Mermelstein (CA Bar 208005)
mmermelstein@orrick.com
ORRICK, HERRINGTON &
SUTCLIFFE LLP
777 South Figueroa Street
Suite 3200
Los Angeles, CA 90017
Tel: (213) 629-2020
Fax: (213) 612-2499

Leigh Coutoumanos**
lcoutoumanos@willkie.com
WILLKIE FARR &
GALLAGHER LLP
1875 K Street NW, Suite 100
Washington, DC 20006
Tel: (202) 303-1000
Fax: (202) 303-2000

Shalini Goel Agarwal
(CA Bar 254540)
shalini.agarwal@splcenter.org
SOUTHERN POVERTY LAW
CENTER
106 East College Avenue
Suite 1010
Tallahassee, FL 32301
Tel: (850) 521-3024
Fax: (850) 521-3001

Maria del Pilar Gonzalez Morales
(CA Bar 308550)
pgonzalez@creeclaw.org
CIVIL RIGHTS EDUCATION
AND ENFORCEMENT CENTER
1825 N. Vermont Avenue, #27916
Los Angeles, CA 90027
Tel: (805) 813-8896
Fax: (303) 872-9072

26 Attorneys for Plaintiffs (continued from previous page)

27 *Admitted Pro Hac Vice

28 **Pro Hac Vice Application Forthcoming

Declaration of Dr. Carlos Franco-Paredes

The Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), is a newly emerging zoonotic agent initially identified in December 2019 that, as of today, has spread to more than 150 countries causing 297,000 confirmed cases and 12,755 deaths^a. This viral pathogen causes the Coronavirus Disease 2019 (COVID-19). Infection with COVID-19 is associated with significant morbidity and mortality especially in patients above 55 years of age and those with chronic medical conditions^{b,c,d}.

Immigration detention centers in the U.S. are tinderboxes for the transmission of highly transmissible infectious pathogens including the SARS-CoV-2, which causes COVID-19. Given the large population density of immigration detention centers and the ease of transmission of this viral pathogen, the attack rate inside these centers will take exponential proportions, consuming significant medical and financial resources.

As an infectious disease clinician with a public health degree in the dynamics of infectious disease epidemics and pandemics and twenty years of clinical experience, I am concerned about the treatment of immigrants inside detention centers which could make the current COVID-19 epidemic worse in the U.S. by having a high case fatality rate among detainees and potentially spreading the outbreak into the larger community. A copy of my CV is presented in Exhibit A.

I have experience providing care to individuals in a civil detention center and have performed approximately two medical forensic examinations and fifteen medical second opinion evaluations for patients in the custody of the Department of Homeland Security (DHS). Based on my conversations with patients, my own observations, and information that exists regarding the resources available within immigration detention facilities as detailed by the ICE Health Services Corps, it is my professional opinion that the medical care available in DHS custody cannot

properly accommodate the needs of patients should there be an outbreak of COVID-19 in an immigration detention facility. The physical and emotional trauma that detainees and asylum seekers experience can weaken their immune systems, resulting in increased risk of severe manifestations of infections. For example cases of influenza virus infections causing pneumonia and respiratory failure, - albeit influenza infection is not as communicable and not transmitted during asymptomatic infection as it is the case with SARS-CoV-2 -, has caused human deaths inside immigration detention centers ^c.

- **For people in the highest risk populations, the fatality rate of COVID-19 infection is about 15 percent.**

According to the CDC, groups deemed to be at high risk of developing severe disease and dying from COVID-19 include those above 55 years of age and those with underlying medical conditions (regardless of their age) (See Table 1). These cases are also amplifiers or hyper-spreaders of the infection since they tend to have high viral concentrations in their respiratory secretions.

The clinical experience in China, South Korea, Italy and Spain has shown that 80% of confirmed cases tend to occur in persons 30-69 years of age regardless of whether they had underlying medical conditions. Of these, 20% develop severe clinical manifestations or become critically ill. Among those with severe clinical manifestations, regardless of their age or underlying medical conditions, the virus progresses into respiratory failure, septic shock, and multiorgan dysfunction requiring intensive care support including the use of mechanical ventilator support. The overall case fatality rate is 10-14% of those who develop severe disease. In China, 80% of deaths occurred among adults ≥ 60 years^c.

Table 1. Risk factors for developing severe disease and death outside the U.S.

Age groups at high risk of developing severe disease and dying without underlying medical	50-59 years (1% CFR)* 60-69 years (3.6% CFR) 70-79 years (8% CFR)
--	---

1	conditions	
2	Groups with underlying medical	-Cardiovascular Disease (congestive
3	conditions at high risk of dying	heart failure, history of myocardial
4	regardless of their age	infarction, history of cardiac surgery)
5		-Systemic Arterial Hypertension (high
6		blood pressure)
7		-Chronic Respiratory Disease (asthma,
8		chronic obstructive pulmonary disease
9		including chronic bronchitis or
10		emphysema, or other pulmonary
11		diseases)
12		-Diabetes Mellitus
13		-Cancer
14		-Chronic Liver Disease
15		-Chronic Kidney Disease
16		-Autoimmune Diseases (psoriasis,
17		rheumatoid arthritis, systemic lupus
18		erythematosus)
19		-Severe Psychiatric Illness **
20		-History of Transplantation
21		-HIV/AIDS
22		-Pregnancy***
23		

24 *CFR= Case Fatality Rate. This is an indicator of lethality used during outbreaks to identify the number of
individuals who succumb out of those infected.

25 ** In South Korea, 20% of deaths occurred in what they defined as Psychiatric Illness (J Korean Med Sci 2020;
35(10): e112).

26 *** Extrapolation from previous influenza pandemics including the 2009 pandemic that increased pregnancy-related
mortality 4-fold particularly during second and third trimesters. The reason is due to immune mediated changes
27 during pregnancy and lung function compromise due to gravid uterus (Omer S. N Engl J Med 2017;376(13): 1256-
1267.

1 There is a growing number of confirmed cases in the U.S., increasing
2 number of hospitalizations and admissions to intensive care units, and many
3 deaths. In this wave of the pandemic or in subsequent ones, it is likely the number
4 of infected individuals will continue to augment. In the closed settings of
5 immigration detention centers, where there is overcrowding and confinement of a
6 large number of persons, networks of transmission become highly conducive to
7 spread rapidly.

8 As of March 16, 2020^c, cases of COVID-19 in the U.S. reported by the CDC
9 shows that 31% of COVID-19 cases, 45% of hospitalizations, and 80% of deaths
10 occurred among adults > 65 years of age. Case-fatality in persons aged > 85 ranged
11 from 10-27%, followed by 3-11% among persons aged 65-84 years, 1% among
12 persons aged 55-64 and <1% among persons 20-54 years of age.

13 Reports by the Chinese CDC demonstrate that the case fatality rate is highest among critical
14 cases in the high-risk categories with COVID at 49%^f. Case fatality was higher for patients with
15 comorbidities: 10.5% for those with cardiovascular disease, 7% for diabetes, and 6% each for
16 chronic respiratory disease, hypertension, and cancer. Case fatality for patients who developed
17 respiratory failure, septic shock, or multiple organ dysfunction was 49%^b.

- 18 • **For people with these risk factors, COVID-19 can severely damage**
19 **lung tissue, which requires an extensive period of rehabilitation, and**
20 **in some cases, can cause permanent loss of respiratory capacity.**
21

22 There is preliminary evidence that persons with COVID-19 who are
23 recovering from severe disease and who have developed extensive pulmonary
24 disease including Acute Respiratory Distress Syndrome (ARDS)^g may have long-
25 term sequelae similar to other infectious pathogens evolving in a similar pattern.
26 Long term sequelae of those with sepsis, ARDS and respiratory failure identified in
27 the literature include long-term cognitive impairment, psychological morbidities,
28 neuromuscular weakness, pulmonary dysfunction, and ongoing healthcare

utilization with reduced quality of life^h and need for rehabilitation servicesⁱ.

- **COVID-19 may also target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.**

The full description of the pathogenesis of COVID-19 requires to be completely elucidated. However, there is clinical evidence that in addition to the severe lung injury associated to this viral infection, some persons may also develop myocardial involvement that appears to be the result of either direct viral infection or caused by the immune response to SARS-CoV-2. From the published case reports, myocarditis caused by this viral pathogen is associated with congestive heart failure, cardiac arrhythmias and death^j. Similar to other viral myocarditis, most patients may develop long-term myocardial damage^k.

- **Emerging evidence also suggests that COVID-19 can trigger an over-response of the immune system, further damaging tissues in a cytokine release syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury. These complications can manifest at an alarming pace.**

Among persons infected with SARS-CoV-2 and developing COVID-19, severe disease systemic inflammation is associated with adverse outcomes^l. However, there is evidence that the use of corticosteroids have not shown benefit and they might be more likely to cause harm when administered to persons with ARDS caused by COVID-19^m. Similar to influenza infection, acute lung injury and

acute respiratory distress syndrome are most likely caused by the respiratory epithelial membrane dysfunction leading to acute respiratory distress syndrome^{l,n}. Preliminary evidence from case reports and small cases series from China and South Korea confirm that there is minimal inflammation and evidence of cell necrosis in the form of apoptosis of the respiratory epithelium^o. The resultant tissue hypoxia is responsible and potential concomitant bacterial sepsis contribute to multiorgan dysfunction and death. If a patient with COVID-19 develops myocarditis, cardiogenic shock caused by fulminant myocarditis may also contribute to the overall occurrence of multiple organ failure^k.

- **Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in five days or sooner.**

There is evidence of substantial undocumented infection facilitating the rapid dissemination of novel coronavirus SARS-CoV-2 which is responsible for 79% of documented cases of COVID-19 in China^o. Once an individual is exposed to this virus from either a symptomatic individual (21% of cases) or from asymptomatic individuals (79% of cases), the shortest incubation period is 3 days with a median incubation period of 5.1 (95% CI 4.5 to 5.8 days)^p. Overall, 97.5% of persons who develop symptoms do so within 11.5 days of the initial exposure^p. Most persons with COVID-19 who develop severe disease do so immediately after admission or within 3-5 days from their initial presentation^{c,q} and represent 53% of those requiring intensive care unit admissions and advanced supportive care^c. At my current institution, the two confirmed deaths occurred within 48 hours of admission to the hospital.

- **Most people in higher risk categories who develop serious disease will need advanced support. This level of supportive care requires highly specialized equipment that is in limited supply, and an entire**

1 **team of care providers, including 1:1 or 1:2 nurse to patient ratios,**
2 **respiratory therapists, and intensive care physicians. This level of**
3 **support can quickly exceed local health care resources.**

4 There is sufficient evidence that the SARS-CoV-2 pandemic has an
5 overwhelming impact in healthcare utilization in all settings (China, South Korea,
6 Italy, France, Germany, and others). In the U.S.^c, current evidence demonstrates
7 that COVID-19 can result in severe disease, including hospitalization (31%) and
8 admission to an intensive care unit (53% of ICU admissions). To respond to this
9 overwhelming demand in ICU admissions, there is a need for a multidisciplinary
10 approach that is time consuming and requires highly trained personnel including
11 pulmonary and critical care physicians, nurses, respiratory therapists,
12 phlebotomists, social workers, and case managers. The care of this group of
13 patients also requires subspecialists including nephrologists, infectious disease
14 physicians, hematologists, hospitalists, and others. Patients on mechanical
15 ventilation or requiring extracorporeal membrane oxygenation require additional
16 staff including perfusionists and 1:1 dedicated nursing care. Currently, medical
17 centers in many urban and rural settings in the U.S. are functioning at full capacity.
18 Therefore, preventing the occurrence of an outbreak within a detention facility
19 would reduce the risk of overwhelming local healthcare systems. Indeed, a
20 potential outbreak occurring within an immigration detention center, the number of
21 detainees who will require transfer outside the facility for specialized care may
22 exceed the capacity of local hospitals. This is particularly important in rural and
23 semirural settings where many immigration detention centers are located, and
24 where they may have contact with a limited number of surrounding medical
25 centers.

26
27 **Conclusions:**

28 There is a need to proactively consider alternative strategies to dilute the

1 potential community-based impact of an outbreak inside immigration detention
2 centers. Therefore, it is my professional view that releasing detainees/asylum
3 seekers on humanitarian parole from these centers constitutes a high-yield public
4 health intervention that may significantly lessen the impact of this outbreak not
5 only within detention centers but among the communities surrounding these
6 centers. In particular, targeting the release of persons in the age groups at risk of
7 severe disease and death; and persons with underlying medical conditions, may
8 lessen the human and financial costs that this outbreak may eventually impose on
9 ICE detention facilities nationwide. Responding to an outbreak requires significant
10 improvements in staffing, upgrading medical equipment, substantial supplies
11 including antibiotics, intravenous infusions, cardiac and respiratory monitors,
12 devices for oxygen supply, and personal protection supplies among persons at high
13 risk of severe COVID-19 disease.

14
15 A large outbreak of COVID-19 in an immigration detention facility would
16 put a tremendous strain on the medical system to the detriment of patients in the
17 communities surrounding these centers. It is reasonable to anticipate that there will
18 be the loss of additional lives that could have otherwise been saved.

19
20 I declare under penalty of perjury that the statements above are true and correct to
21 the best of my knowledge.

22
23 Date: March 21, 2020

24
25 A handwritten signature in black ink, appearing to read 'C. Franco-Paredes', is written over a light gray rectangular background.

26
27
28 Carlos Franco-Paredes, MD, MPH, DTMH (Gorgas)
Associate Professor of Medicine

1 Division of Infectious Diseases
2 Department of Medicine
3 Program Director Infectious Disease Fellowship
4 Training Program, University of Colorado
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

References

- a. Johns Hopkins University. Coronavirus Resource Center Available at: <https://coronavirus.jhu.edu/map.html>. Accessed: March 21, 2020.
- b. CDC-Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) Available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>). Accessed: March 21, 2020.
- c. CDC COVID 19 Response Team. Severe outcomes among patients with coronavirus disease 2019 (COVID-19) – United States, February 12-March 16, 2020. Available at: <https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm>. Accessed: March 21, 2020.
- d. Rodriguez-Morales AJ, Cardona-Ospina JA, Gutiérrez-Ocampo E, Villamizar-Peña R, Holguin-Rivera Y, Escalera-Antezana JP, Alvarado-Arnez LE, Bonilla-Aldana DK, Franco-Paredes C, Henao-Martínez AF, Paniz-Mondolfi A, Lagos-Grisales GJ, Ramírez-Vallejo E, Suárez JA, Zambrano LI, Villamil-Gómez WE, Balbin-Ramón GJ, Rabaan AA, Harapan H, Dhama K, Nishiura H, Kataoka H, Ahmad T, Sah R; Latin American Network of Coronavirus Disease 2019-COVID-19 Research (LANCOVID-19). Electronic address: <https://www.lancovid.org>. [Clinical, laboratory and imaging features of COVID-19: A systematic review and meta-analysis](#). *Travel Med Infect Dis*. 2020 Mar 13:101623. doi: 10.1016/j.tmaid.2020.101623. [Epub ahead of print].
- e. Foppian Palacios C, Openshaw JJ, Travassos MA. Influenza in U.S. detention centers- the desperate need for immunization. *N Engl J Med* 2020; 382(9): 789-792.
- f. [Novel Coronavirus Pneumonia Emergency Response Epidemiology Team](#) [external icon](#) [external icon](#). [The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) in China]. *Zhonghua Liu Xing Bing Xue Za Zhi*. 2020;41(2):145–151. DOI:10.3760/cma.j.issn.0254-6450.2020.02.003.
- g. Mart M, Ware LB. The long-lasting effects of the acute respiratory distress syndrome. *Expert Rev Respir Dis* 2020; <https://doi.org/10.1080/17476348.2020.1743182>.
- h. Wu C, Chen X, Cai Y, Xia J, Zhou X, Xu S, Huang H, Zhang L, Zhou X, Du C, Zhang Y, Song J, Wang S, Chao Y, Yang Z, Xu J, Zhou X, Chen D, Xiong W, Xu L, Zhou F, Jiang J, Bai C, Zheng J, Song Y. [Risk Factors Associated With Acute Respiratory Distress Syndrome and Death in Patients With Coronavirus Disease 2019 Pneumonia in Wuhan, China](#). *JAMA Intern Med*. 2020 Mar 13. doi: 10.1001/jamainternmed.2020.0994. [Epub ahead of print].
- i. Koh GC, Hoenig H. How should the rehabilitation community prepare for 2019-nCoV? *Arch Phys Med Rehabil* 2020 Mar 16. pii: S0003-9993(20)30153-2. Doi: 10.1016/j.apmr.2020.03.003. (Epub ahead of print).
- j. Chen C, Zhou Y, Wen WD. SARS-CoV-2: a potential novel etiology of fulminant myocarditis. *Herz* 2020; March 5. <https://doi.org/10.1007/s00059-020-04909-z>.
- k. Hu H, Ma F, Wei X, Fang Y. Coronavirus fulminant myocarditis saved with glucocorticoid and human immunoglobulin. *Eur Heart J* 2020; Mar 16. [Epub ahead of print].
- l. Li R, Pei S, Chen B, Song , Zhang T, Shaman J. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). *Science* 10.1126/scienceabb3221 (2020).
- m. Russell CD, Millar JE, Baillie JK. Clinical evidence does not support corticosteroid treatment for 2019-nCoV lung injury. *Lancet Infect Dis* 2020; 395: 474-475.
- n. [Hoffmann M](#), [Kleine-Weber H](#), [Schroeder S](#), [Krüger N](#), [Herrler T](#), [Erichsen S](#), [Schiergens TS](#), [Herrler G](#), [Wu NH](#), [Nitsche A](#), [Müller MA](#), [Drosten C](#), [Pöhlmann S](#) SARS-CoV-2 Cell Entry Depends on ACE2 and TMPRSS2 and Is Blocked by a Clinically Proven Protease Inhibitor. [Cell](#). 2020 Mar 4. pii: S0092-8674(20)30229-4. doi: 10.1016/j.cell.2020.02.052. [Epub ahead of print]
- o. Tian S, Hu W, Niu L, Liu H, Su H, Xiao SY. Pulmonary pathology of early phase 2019 novel coronavirus (COVID-19) pneumonia in patients with lung cancer. *J Thorac Oncol* 2020; <https://doi.org/10.1016/j.tho.2020.02.010>.
- p. [Lauer SA](#), [Grantz KH](#), [Bi Q](#), [Jones FK](#), [Zheng Q](#), [Meredith HR](#), [Azman AS](#), [Reich NG](#), [Lessler J](#). The incubation period of coronavirus disease 2019 (COVID-19) from publicly reported confirmed cases: estimation and application. *Ann Intern Med* 2020; March 10, doi: <https://doi.org/107326/M20-0504>.
- q. Korean Society of Infectious Diseases; Korean Society of Pediatric Infectious Diseases; Korean Society of Epidemiology; Korean Society for Antimicrobial Therapy; Korean Society for Healthcare-associated

1 Infection Control and Prevention; Korea Centers for Disease Control and Prevention. [Report on the](#)
2 [Epidemiological Features of Coronavirus Disease 2019 \(COVID-19\) Outbreak in the Republic of](#)
3 [Korea from January 19 to March 2, 2020](#). J Korean Med Sci. 2020 Mar 16;35(10):e112. doi:
4 10.3346/jkms.2020.35.e112.
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28