

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CHARLES RUSSELL, *et al.*,
individually and on behalf of all
others similarly situated,

Plaintiffs,

v.

WAYNE COUNTY, MICHIGAN;
BENNY NAPOLEON, in his official
capacity as the Sheriff of Wayne
County, *et al.*,

Defendants.

Case No.

Class Action

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

EXHIBIT

DESCRIPTION

- | | |
|---|---|
| 1 | Declaration of Dr. Marc Stern |
| 2 | Declaration of Dr. Jaime Meyer |
| 3 | Declaration of Elizabeth Y. Chiao |
| 4 | Declaration of Dr. Jonathan Golob |
| 5 | Declaration of Dr. Carlos Franco-Paredes |
| 6 | Declaration of Dr. Carlos Franco-Paredes (Oakland
County Jail) |

- 7 *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* CDC.gov
- 8 March 25, 2020 letter to Governor Larry Hogan from the faculty members of the Johns Hopkins Bloomberg School of Public Health, et al.
- 9 March 12, 2020 letter to Mayor de Blasio and City Officials from NYC Council Members Brad Lander and Ritchie Torres
- 10 Declaration of Ranit Mishori, MD, MHS, FAAFP filed in the United States District Court for the District of Maryland
- 11 Declaration of Robert B. Greifinger, MD filed in Case 2:20-cv-00409-JLR-MAT Document 4
- 12 Michigan Executive Order 2020-29 (COVID-19)
- 13 March 31, 2020 letter to Michigan sheriffs from the ACLU
- 14 Declaration of Dr. Adam Lauring
- 15 Amended Opinion and Order Granting in Part Petitioner's Emergency Application for a Temporary Restraining
- 16 Expert Declaration of Dr. Amir Moheb Mohareb Filed in *Mays v. Dart*, Case No. 20-cv-2134 (April 3, 2020)

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.

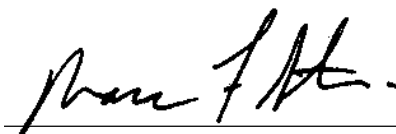
14. For the first time in history, large scale decisions about incarceration need to be made on the basis of public safety, not only considering criminal justice-related factors, but also public health-related factors.

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

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

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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

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

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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

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

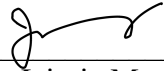
36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These 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
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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.
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Exhibit B – Declaration of Dr. Elizabeth Y. Chiao

**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
	)	(Class Action)
HARRIS COUNTY, TEXAS, et al.	)	The Honorable Lee H. Rosenthal
	)	U.S. District Judge
Defendants.	)	
	)	

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.nccchc.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.

Günther

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](#)
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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. AAHIMV, 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 "G. M. M. D." or similar, written in a cursive style.

Last updated 12/30/2019

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

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

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

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

**DECLARATION OF
DR. CARLOS FRANCO-PAREDES**

Date: March 24, 2020

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Attorneys for Plaintiffs (continued from previous page)

*Admitted Pro Hac Vice

**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 $\geq$ 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)
--	---

conditions	
Groups with underlying medical conditions at high risk of dying regardless of their age	-Cardiovascular Disease (congestive heart failure, history of myocardial infarction, history of cardiac surgery) -Systemic Arterial Hypertension (high blood pressure) -Chronic Respiratory Disease (asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases) -Diabetes Mellitus -Cancer -Chronic Liver Disease -Chronic Kidney Disease -Autoimmune Diseases (psoriasis, rheumatoid arthritis, systemic lupus erythematosus) -Severe Psychiatric Illness ** -History of Transplantation -HIV/AIDS -Pregnancy***

*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.

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

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

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.

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23 Date: March 21, 2020

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28 Carlos Franco-Paredes, MD, MPH, DTMH (Gorgas)
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UNITED STATES DISTRICT COURT
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. 20-cv-10949

Hon. Linda V. Parker

Declaration of Dr. Carlos Franco-Paredes – Oakland County Jail

Declaration of Dr. Carlos Franco-Paredes – Oakland County Jail

FORMAL ASSESSMENT

Executive Summary: My overarching recommendation is an urgent reduction in the inmate population of the Oakland County Jail (“Jail”) and increased screening of COVID-19 infection among the staff and inmates. Although leadership and staff at the Jail have instituted some interventions to mitigate the impact of COVID-19 and improve the safety of the inmate population, these interventions are insufficient to interrupt the transmission of COVID-19 infection, unless social distancing is also meaningfully implemented. However implementing social distancing inside the Jail is impossible at current jail population levels. Therefore, reducing the inmate population to allow for effective social distancing is the only way to protect medically vulnerable inmates. Medically vulnerable inmates are at a substantial risk of contracting, spreading and becoming seriously ill or dying from COVID-19 in any carceral setting, but particularly in this Jail where there is an active outbreak of the virus. Inmates at high-risk of severe disease and death from COVID-19 infection need to be identified, and released unless they can be confined in conditions that provide for 24-7 social distancing.

Additionally, I recommend further measures in this report that the Jail should immediately implement to more effectively mitigate the serious risk of harm posed by this virus.

COVID-19 in the State of Michigan, Oakland County, and the Oakland County Jail

The State of Michigan has 37,203 confirmed cases of COVID-19 with 3,274 deaths. After Wayne County, Oakland County is the second county with the highest number of cases (6881) and the second with the highest number of deaths (612). There is an active outbreak of cases of Covid-19. On April 3, it was reported that the Oakland County jail had 6 cases, and by April 11 they had 23 cases. The jail would not provide me with information on the number of current confirmed cases. I therefore asked counsel for Plaintiffs, who informed me that the Jail has acknowledged in litigation documents that there have been at least 36 confirmed cases.

Oakland County Jail Observations

1. Social Distancing:

- a. **Main Jail building**: In the main Jail building, which holds most of the inmate population, it would be impossible to accomplish proper social distancing at anything near the current population. CDC guidelines state that social distancing *“strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities.”* However, nothing in the CDC guidelines says that it is safe to fail to provide inmates with the ability to observe full social distancing. During an outbreak such as the one occurring in the Jail, a reduction in the inmate population is urgently needed to accommodate further social distancing, particularly in the main building. Transferring inmates to other locations would not be sufficient. The entire main building does not provide sufficient opportunities for social distancing, and although the annex is somewhat less crowded, transferring inmates there may only shift the worst of the social distancing problem from the main building where there is an active outbreak, to the annex. Moving inmates to the annex would also run a risk of bringing the outbreak into the annex. Insufficient social distancing is especially severe in the receiving unit of the main building and in the holding pods. (See picture from 2nd floor main jail – Cell B1c from outer catwalk, attached further in this report.) In these holding pods, there is severe overcrowding and toilet hygiene is insufficient to adequately prevent spread of the infection. There is also close contact between receiving units and holding blocks such that if new inmates arrive who are infected, they may potentially infect those who are being housed in the holding blocks.
- b. **Annex**: Adequate social distancing also remains a concern in the Annex, but not as significant as in the main building. Additionally, the shared bathrooms and social space in the East Annex pose a serious problem, because facilities are shared by a large number of people, thus making social distancing unfeasible and raising the likelihood that an infection will spread via the shared facilities.
- c. **East Annex**: Adequate social distancing also remains a concern in the East Annex, but not as significant as in the main building. Additionally, the shared bathrooms and social space in the East Annex pose a serious

problem, because facilities are shared by many people, thus making social distancing unfeasible and raising the likelihood that an infection will spread via the shared facilities.

2. **Medical care:** The Oakland County correctional staff did not answer my questions about the medical care being provided to inmates with COVID-19, including protocols as to what happens to inmates who develop severe disease and protocols for transfer to a local hospital for treatment. They would not discuss the number of confirmed cases, how cases are confirmed, or how patients are selected for testing. As a result, I did not receive sufficient information to properly assess whether the facility is providing adequate medical care to inmates at the Jail. Significantly, my inspection did not reveal any additional measures being taken to protect medically vulnerable inmates, who appeared to be mixed in with the general population.

3. **Cleanliness:** In the Annex, trustees are responsible for cleaning bathrooms once every shift change of security officers. Most inmates, however, reported that cleaning is left entirely to the inmates and is voluntary. Additionally, the Jail's cleaning measures are not enough to prevent the spread of COVID-19 in shared bathroom facilities. Toilets and showers need to be cleaned after every use in order to provide proper protections and the Jail has not taken measures to allow for the necessary cleaning. Toilets are a particularly serious transmission concern because they have no lids, and because fecal matter can disperse with each flush and presents a particularly efficient pathway of transmission. During my inspection, I observed that all staff and inmates had masks on. The three jail buildings had sufficient cleaning supplies and disinfection products, but I was not able to discern whether inmates have sufficient access to them. Some inmates, particularly in the holding area of the main Jail building, reported not receiving sufficient quantities of soap. The Jail staff did not provide me with any information on how often personal hygiene supplies are made available to inmates or how often disinfectant supplies are replaced. One of the female inmates that I interviewed in the Annex reported to me that she was required to clean and disinfect cells previously occupied by female inmates that were newly admitted to the jail. She had cleaning products, but did not have the type of specialized mask that could prevent her from becoming infected if asked to clean an infected cell. She was not informed of the infectious status of any of the female inmates housed in the cells she was required to clean. In addition, inmates in the Annex regularly need to pass by the cells where transient inmates are housed. This means that many inmates in the Annex are potentially exposed to infection from new intakes.

4. **Mitigation Efforts:** During my inspection, I observed that the Jail has been implementing some mitigating interventions according to CDC guidelines including halting all group activities, staggering pod time and limiting the number of people on the pod at any given time; providing inmates with masks, isolating some sick inmates; performing limited testing of sick inmates; making cleaning supplies readily available; and providing education materials regarding COVID-19 to inmates. I was not able to discern how long most of these measures have been in place, and whether inmates had recently been moved. I observed COVID-19 materials posted on the walls in all three Jail buildings, but I was unable to confirm how long these materials had been posted on the walls. It appeared to me that many of these materials were recently posted given how clean the pages were.

COVID-19 in Correctional Facilities:

As recent evidence indicates from custodial settings in other States such as in Ohio, and from Sterling prison in Colorado, even a small outbreak of COVID-19 cases reflects just the tip of the iceberg of a larger outbreak with a larger number of undetected cases in those with no symptoms or mild symptoms. The number of people who are asymptomatic or exhibiting mild symptoms may represent up to 80% of those with coronavirus infection that are responsible for transmitting more than 44% of the cases.

For example, in Sterling Correctional Facility, when the Department of Corrections performed prevalence testing after only a few confirmed cases of COVID-19 among symptomatic inmates, they identified another 138 infected inmates. For this pandemic, the use of temperature screens and assessment of symptoms, which is what the Jail is relying upon for most screenings, is insufficient when instituted in correctional facilities; and furthermore, it may actually foster further transmission by providing a false sense of security. In fact, in physician forums, there is an urgent call to ask CDC to update their recommendations as well as move towards universal testing in correctional facilities.

This unprecedented pandemic calls for unprecedented measures in every setting but particularly in congregate settings. No one living inside the Jail or outside in the larger community is safe until there is interruption of coronavirus transmission.

Recommendations

In response to the COVID-19 outbreak, the leadership and the staff at the Jail have instituted some interventions to mitigate the impact of COVID-19 and improve the

safety of the inmate population, but I was unable to discern how long these interventions have been in place. It was not possible to discern whether the desirable measures that I witnessed, such as providing disinfectant and masks have been ongoing for a significant period of time. After conducting my inspection of the Jail, where I had the opportunity to speak with inmates and observe the dynamics of the different buildings (main, annex, and east annex), it is my opinion that additional interventions are necessary to protect inmate, staff, and ultimately strengthen community safety and address the following three major issues:

1. Diffusing Density

- Evidence of mass outbreaks from other jail and prison settings validates that even when excellent infection control practices are in place, if they are coupled with incomplete or inconsistent adherence to social distancing, these practices will be insufficient to **contain** the occurrence of new cases. Especially in settings such as Oakland County, where there is ongoing sustained transmission of COVID-19 within the broader community.
- Social distancing requires inmates maintaining a distance of at least six feet from each other at all times. Additionally, disinfection of key areas (telephones and toilets), mask use, and regular handwashing must be meticulously followed. These protocols are necessary to prevent spread of COVID-19 among otherwise healthy people. These protocols are especially imperative for high-risk individuals. Without these protocols, high-risk individuals face a substantial risk of serious illness or death from this infection.
- To the extent that inmates at risk of severe disease or death cannot be released, medically vulnerable individuals should be housed in single-person cells to mitigate the risk of serious illness or death to this population. All current inmates and new inmates should be immediately screened to determine if they meet the criteria for high risk noted in Table 1 of this report.

2. Testing for COVID-19 is Critical

- It is my opinion based on increasing evidence and recent publications that expanding testing capabilities will improve isolation and quarantine strategies at the Jail. There are some ongoing efforts at the Jail to test inmates. However, I was not able to discern how inmates are selected for testing, and Jail staff refused to answer any questions

about this subject. Temperature checks are insufficient; expanding testing to identify asymptomatic inmates with COVID-19 infection is a necessary, but not sufficient, measure to combat this epidemic inside the Jail. For example, in custodial settings in Ohio, the rate of asymptomatic and symptomatic infection in an enclosed jail environment could reach up to 70% (with more than 20% asymptomatic infection). A similar ratio of symptomatic to asymptomatic ratio was identified and reported at Sterling Prison in Colorado.

- Priorities for testing:
 - Test newly admitted inmates for novel coronavirus infection even if asymptomatic to reduce the risk of new introductions into the Jail. There is no other way to effectively screen asymptomatic people at intake.
 - Any inmate at the Jail with one or more symptoms consistent with COVID-19 should undergo a clinical assessment including testing for the presence of the novel coronavirus SARS-CoV-2 in nasopharynx. It should never be assumed that an inmate who reports illness and some symptoms is not infected simply because the inmate does not exhibit *all* of the symptoms or any particular symptom (such as a high temperature).
 - Ideally, all Jail inmates and staff should be tested, to guide isolation and quarantine practices. Alternatively, prevalence testing is reasonable.

3. Prevention of exposure to the novel coronavirus

- Institute directives for all inmates in all units to use disinfectant and clean telephones after each use.
- Institute directives for all inmates in all units to use disinfectant prior to and after the use of toilettes.
- Enforce guidance on bed positions:
 - For single beds positioned next to each other (side-to side): provide at least 6 feet of space and ensure that inmates' are positioned head to toe while sleeping.
 - For bunkbeds that are positioned next to each other or across from one another: Position beds at least 6 feet apart. Ensure the inmate's laying position is head to toe on each separate bunk

bed, so positioning allows for the least transmission risk as possible. This includes laying position that is head to toe with adjacent bunks.

- Enforce social distancing practices of all inmates in all units during med-line or meal-line
- Inmates exhibiting COVID-19 symptoms should not be required to clean their own cell and no inmate should clean up after other inmates.
- Professional janitorial services should be brought in to disinfect the male medical isolation unit or any unit, which may become quarantined in the near future.
- Under no circumstances should inmates in the two annex buildings be moved into the already crowded main jail building. Transfers of this nature increase the severity of the lack of social distancing in the main building and put the transferred inmates at greatly increased risk of infection.

Table 1. Risk factors for developing severe disease and death

Age groups at high risk of developing severe disease and dying without underlying medical conditions	≥ 50 years (1% CFR)* 60-69 years (3.6% CFR) 70-79 years (8% CFR)
High risk groups of dying with underlying medical conditions regardless of their age	-Cardiovascular disease (congestive heart failure, history of myocardial infarction, history of cardiac surgery) -Systemic Arterial Hypertension (High Blood Pressure) Chronic respiratory disease (asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases) -Diabetes mellitus

	-Cancer -Chronic Liver Disease -Chronic Kidney Disease -Autoimmune Diseases -Severe Psychiatric Illness ** -History of transplantation -Immune suppression (HIV/AIDS, glucocorticoids, other immunosuppressant drugs, history of smoking) -Pregnancy
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*CFR= Case Fatality Rate is an indicator used during outbreaks to identify the number of individuals who succumb out of those who become infected ** In South Korea, 20% of deaths occurred in what they defined as Psychiatric Illness (J Korean Med Sci 2020; 35(10): e112).

Photo Redacted

Social distancing (6 feet) is also impossible in the receiving male and female areas as shown in image below in Main Jail Receiving - Cells R3, R4, R5

Photo Redacted

CONCLUSIONS

The leadership and staff at Oakland County Jail have in place some interventions as per CDC recommendations for COVID-19.

However, as I have observed in other correctional facilities, adhering to some CDC recommendations to contain and mitigate a COVID-19 outbreak without implementing all of them and, critically, without the ability to achieve social distancing is insufficient to stop its spread. This epidemiological situation is not unique to Oakland County jail; it applies to all correctional facilities as witnessed by the growing number of outbreaks within correctional facilities with increasing

number of cases and deaths. This is a severe pandemic caused by a highly transmissible virus in crowded settings.

Therefore, the single most important intervention in controlling a COVID-19 outbreak at Oakland County Jail is continuing to reduce population density to achieve meaning social distancing. In this context, unless more inmates are released from jail, protecting the medically vulnerable at high risk of developing severe disease and dying from COVID-19, is certainly almost impossible with current interventions.

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

Date: April 27, 2020

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

Carlos Franco-Paredes, MD, MPH, DTMH (Gorgas)

Associate Professor of Medicine

DOCUMENTS REVIEWED FOR THIS DECLARATION

Declarations:

1. Captain Curtis Childs Affidavit.
2. Vicky-Lyn Warren Affidavit.
3. Sergeant Ryan Terry
4. Daily Inmate Population Report for 4/17/2020 by the Oakland County Sheriff's Office.
5. Inspection Order by Honorable Linda V. Parker.

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22. Sanche S, Lin YT, Xu C, Romero-Severson E, Hengartner N, Ke R. High contagiousness and rapid spread of severe acute respiratory syndrome coronavirus 2. *Emerg Infect Dis.* 2020 Jul <https://doi.org/10.3201/eid2607.200282>.
23. Swerdlow DL, Finelli L. Preparation for possible sustained transmission of 2019 Novel Coronavirus. Lessons from previous pandemics. *JAMA* 2020; 323(12): 1129-30.
24. Patrozou E, Mermel LA. Does influenza transmission occur from asymptomatic infection or prior to symptom onset? *Public Health Rep* 2009; 124: 193-96.
25. Thompson R. Pandemic potential of 2019-nCoV. *Lancet Infect Dis* 2020; 20 March 20; doi.org/10.1016/S1473-3099 (20)30068-2.
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27. World Prisons Brief. COVID-19 in prisons: a major public health risk. <https://www.prisonstudies.org/news/covid-19-prisons-%E2%80%93-major-public-health-risk>. Accessed: April 27, 2020.
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30. Cabral J, Cuevas AG. Health inequities among Latinos/Hispanics: documentation status as a determinant of health. *J Racial Ethnic Health Disp* 2020; Feb 5. doi: 10.1007/s40615-020-00710-0.
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34. MMWR. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020; March 27, 2020: 69(12): 339-342.
35. The United States Department of Justice. Aging in Prison. National Institute of Corrections. Available at: <https://nicic.gov/aging-prison>. Accessed: April 24, 2020.
36. Williams BA, Stern MF, Mellow j, Safer M, Greifinger RB. Aging in correctional custody: setting a policy agenda for older prisoner health care. *Am J Public Health* 2012; 102(8): 1475-1481.
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39. Arons MM, Hatfield KM, Reddy SC, et al. Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. *N Engl J Med* 2020. DOI: 10.1056/NEJMoa2008457.
40. Sharsftein JM, Becker SJ, Mello MM. Diagnostic testing for the novel coronavirus. *JAMA* 2020; 323(15): 1437-38.
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EXHIBIT A.

PERSONAL INFORMATION

Carlos Franco-Paredes, M.D., M.P.H.

CURRENT PROFESSIONAL POSITION AND ACTIVITIES:

- Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus and Infectious Diseases (July 2018 - ongoing).
- Fellowship Program Director, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus (March 2019- ongoing).

EDUCATION

1989 -1995	M.D. - La Salle University School of Medicine, Mexico City, Mexico
1996-1999	Internship and Residency in Internal Medicine, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellowship in Infectious Diseases, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellow in AIDS International Training and Research Program, NIH Fogarty Institute, Rollins School of Public Health, Emory University, Atlanta, GA
1999 - 2002	Masters Degree in Public Health (M.P.H.) Rollins School of Public Health, Emory University, Atlanta, GA, Global Health Track
2001-2002	Chief Medical Resident, Grady Memorial Hospital, Emory University
	School of Medicine, Atlanta, GA
2006	Diploma Course in Tropical Medicine, Gorgas. University of Alabama, Birmingham and Universidad Cayetano Heredia, Lima Peru

CERTIFICATIONS

- 1999-Present Diplomate in Internal Medicine American Board of
Internal Medicine (Recertification 11/2010-11/2020)
- 2001-present Diplomate in Infectious Diseases, American Board of
Internal Medicine, Infectious Diseases Subspecialty
(Recertification 04/2011-04/2021)
- 2005-present Travel Medicine Certification by the International
Society of Travel Medicine
- 2007-present Tropical Medicine Certification by the American Society
of Tropical Medicine – Diploma in Tropical Medicine and
Hygiene (DTMH - Gorgas)

EMPLOYMENT HISTORY:

- 2002 - 2004 - Advisor to the Director of the National Center for Child and Adolescent Health and of the National Immunization Council (NIP), Ministry of Health Mexico; my activities included critical review of current national health plans on vaccination, infectious diseases, soil-transmitted helminthic control programs; meningococcal disease outbreaks in the jail system, an outbreak of imported measles in 2003-2004 and bioterrorism and influenza pandemic preparedness. I represented the NIP at meetings of the Global Health Security Action Group preparation of National preparedness and response plans for Mexico
- 2005 – 2011- Co-Director Travel Well Clinic, Emory University Emory Midtown Hospital
- 2004- 8/2009 -Assistant Professor of Medicine
Department of Medicine, Division of Infectious Diseases
Emory University School of Medicine, Atlanta GA
- 3/2008-10/2009 Consultant WHO, HQ, Geneva, Influenza Vaccine
- 9/2009- 3/2011 Associate Professor of Medicine
Department of Medicine, Division of Infectious Diseases
Emory University School of Medicine, Atlanta GA
- 1/2007 – 3/2011 Assistant Professor of Public Health
Hubert Department of Global Health
Rollins School of Public Health, Emory University, Atlanta GA

- 4/2011 –5/2013 - Associate Professor of Public Health in Global Health
Hubert Department of Global Health
Rollins School of Public Health, Emory University, Atlanta GA
- 2010 - WHO HQ Consultant for a 4-month-period on the Deployment of H1N1 influenza vaccine in the African Region, Jan to March 2010, Switzerland Geneva, WHO HQ 2010 sponsored by John Snow Inc. USAID, Washington, D.C.
- 2014-2015 - Consultant International Association of Immunization Managers, Regional Meeting of the Middle Eastern and North African Countries and Sub Saharan Africa, held in Durban South Africa, Sept 2014; and as rapporteur of the Inaugural Conference, 3-4 March 2015, Istanbul, Turkey.
- 3/2011- 5/2017 - Phoebe Physician Group –Infectious Diseases Clinician Phoebe Putney Memorial Hospital, Albany, GA.
- 5/2015 - 9/2015 - Consultant Surveillance of Enteric Fever in Asia (Pakistan, Indonesia, Bangladesh, Nepal, India) March 2015-October 2015.
- June 19, 2017-June 31, 2018–Visiting Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver, Anschutz Medical Campus
- June 2004- present - Adjunct Professor of Pediatrics, Division of Clinical Research, Hospital Infantil de México, Federico Gómez, México City, México. Investigador Nacional Nivel II, Sistema Nacional de Investigadores (12/2019); SNI III Sistema Nacional de Investigadores (1/2020-); Investigador Clínico Nivel E, Sistema Nacional de Hospitales

HONORS AND AWARDS

- 1995 Top Graduating Student, La Salle School of Medicine
- 1997 Award for Academic Excellence in Internal Medicine, EUSM
- 1999 Alpha Omega Alpha (AOA) House staff Officer, EUSM
- 2002 Pillar of Excellence Award. Fulton County Department of Health and Wellness Communicable Disease Prevention Branch, Atlanta GA

- 2002 Emory University Humanitarian Award for extraordinary service in Leadership Betterment of the Human Condition the Emory University Rollins School of Public Health
- 2002 Winner of the Essay Contest on the Health of Developing Countries:
 - Causes and Effects in Relation to Economics or Law, sponsored by the Center for International Development at Harvard University and the World Health Organization Commission on Macroeconomics Health with the essay "*Infectious Diseases, Non-zero Sum Thinking and the Developing World*"
- 2002 "James W. Alley" Award for Outstanding Service to Disadvantaged Populations, Rollins School of Public Health of Emory University May 2002. Received during Commencement Ceremony Graduation to obtain the Degree of Masters in Public Health
- 2006 Golden Apple Award for Excellence in Teaching, Emory University, SOM
- 2006 Best Conference Award Conference, "Juha Kokko" Best Conference Department of Medicine, EUSM
- 2007 "Jack Shulman" Award Infectious Disease fellowship, Excellence in Teaching Award, Division of Infectious Diseases, EUSM
- 2007 Emerging Threats in Public Health: Pandemic Influenza CD-ROM, APHA's Public Health Education and Health Promotion Section, Annual Public Health Materials Contest award
- 2009 National Center for Preparedness, Detection, and Control of Infectious Diseases. Honor Award Certificate for an exemplary partnership in clinical and epidemiologic monitoring of illness related to international travel. NCPDCID Recognition Awards Ceremony, April 2009. CDC, Atlanta, GA
- 2012 The ISTM Awards Committee, directed by Prof. Herbert DuPont, selected the article "Rethinking typhoid fever vaccines" in the Journal of Travel Medicine (Best Review Article)

2012 Best Clinical Teacher. Albany Family Medicine
Residency Program

2018 Outstanding Educator Award – Infectious Diseases Fellowship,
Division of Infectious Diseases, University of Colorado,
Anschutz Medical Center, Aurora Colorado

EDITORSHIP AND EDITORIAL BOARDS

2007-Present Deputy/Associate Editor PLoS Neglected Tropical Disease
Public Library of Science

2017-2018 Deputy Editor, Annals of Clinical Microbiology and
Antimicrobials
BMC

2007-2019 Core Faculty International AIDS Society-USA -Travel and Tropical
Medicine/HIV/AIDS

INTERNATIONAL COMMITTEES

2018- Member of the Examination Committee of the International Society of
Travel Medicine. Developing Examination Questions and Proctoring the
Certificate in Traveler's Health Examination
Proctor Certificate of Traveler's Health Examination (CTH) as part of the
International Society of Travel Medicine– 12th Asia-Pacific Travel Health
Conference, Thailand 21-24 March 2019
Proctor Certificate of Traveler's Health Examination (CTH), Atlanta, GA,
September, 2019

PUBLICATIONS

BOOKS

Franco-Paredes C, Santos-Preciado JI. Neglected Tropical Diseases in Latin
America and the Caribbean, Springer-Verlag, 2015. ISBN-13: 978-3709114216
ISBN-10: 3709114217

Franco-Paredes C. Core Concepts in Clinical Infectious Diseases, Academic
Press, Elsevier, March 2016. ISBN: 978-0-12-804423-0

RESEARCH ORIGINAL ARTICLES (clinical, basic science, other) in refereed journals:

1. Del Rio C, **Franco-Paredes C**, Duffus W, Barragan M, Hicks G. Routinely Recommending HIV Testing at a Large Urban Urgent-Care Clinic – Atlanta, GA. *MMWR_Morbid Mortal Wkly Rep* 2001; 50:538-541.
2. Del Rio C, Barragán M, **Franco-Paredes C**. *Pneumocystis carinii* Pneumonia. *N Engl J Med* 2004; 351:1262-1263.
3. Barragan M, Hicks G, Williams M, **Franco-Paredes C**, Duffus W, Del Rio C. Health Literacy is Associated with HIV Test Acceptance. *J Gen Intern Med* 2005; 20:422-425.
4. Rodriguez-Morales A, Arria M, Rojas-Mirabal J, Borges E, Benitez J, Herrera M, Villalobos C, Maldonado A, Rubio N, **Franco-Paredes C**. Lepidopterism Due to the Exposure of the Moth *Hylesia metabus* in Northeastern Venezuela. *Am J Trop Med Hyg* 2005; 73:991-993.
5. Rodriguez-Morales A, Sánchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. White Blood Cell Counts in *Plasmodium vivax*. *J Infect Dis* 2005; 192:1675-1676.
6. **Franco-Paredes C**, Nicolls D, Dismukes R, Kozarsky P. Persistent Tropical Infectious Diseases among Sudanese Refugees Living in the US. *Am J Trop Med Hyg* 2005; 73: 1.
7. Osorio-Pinzon J, Moncada L, **Franco-Paredes C**. Role of Ivermectin in the Treatment of Severe Orbital Myiasis Due to *Cochliomyia hominivorax*. *Clin Infect Dis* 2006; 3: e57-9.
8. Rodriguez-Morales A, **Franco-Paredes C**. Impact of *Plasmodium vivax* Malaria during Pregnancy in Northeastern Venezuela. *Am J Trop Med Hyg* 2006; 74:273-277.
9. Rodriguez-Morales A, Nestor P, Arria M, **Franco-Paredes C**. Impact of Imported Malaria on the Burden of Malaria in Northeastern Venezuela. *J Travel Med* 2006; 13:15-20.
10. Rodríguez-Morales A, Sánchez E, Vargas M, Piccolo C, Colina R, Arria M, **Franco-Paredes C**. Is anemia in *Plasmodium vivax* More Severe and More Frequent than in *Plasmodium falciparum*? *Am J Med* 2006; 119:e9-10.
11. Hicks G, Barragan M, **Franco-Paredes C**, Williams MV, del Rio C. Health Literacy is a Predictor of HIV Knowledge. *Fam Med J* 2006; 10:717-723.
12. Cardenas R, Sandoval C, Rodriguez-Morales A, **Franco-Paredes C**. Impact of Climate Variability in the Occurrence of Leishmaniasis in Northeastern Colombia. *Am J Trop Med Hyg* 2006; 75:273-7.

13. **Franco-Paredes C**, Nicolls D, Dismukes R, Wilson M, Jones D, Workowski K, Kozarsky P. Persistent and Untreated Tropical Infectious Diseases among Sudanese Refugees in the US. *Am J Trop Med Hyg* 2007; 77:633-635.
14. Rodríguez-Morales AJ, Sanchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. Hemoglobin and haematocrit: The Threefold Conversion is also Non Valid for Assessing Anaemia in *Plasmodium vivax* Malaria-endemic Settings. *Malaria J* 2007; 6:166.
15. **Franco-Paredes C**, Jones D, Rodriguez-Morales AJ, Santos-Preciado JI. Improving the Health of Neglected Populations in Latin America. *BMC Public Health* 2007; 7.
16. Kelly C, Hernández I, **Franco-Paredes C**, Del Rio C. The Clinical and Epidemiologic Characteristics of Foreign-born Latinos with HIV/AIDS at an Urban HIV Clinic. *AIDS Reader* 2007; 17:73-88.
17. Hotez PJ, Bottazzi ME, **Franco-Paredes C**, Ault SK, Roses-Periago M. The Neglected Tropical Diseases of Latin America and the Caribbean: Estimated Disease Burden and Distribution and a Roadmap for Control and Elimination. *PLoS Negl Trop Dis* 2008; 2:e300.
18. Tellez I, Barragan M, Nelson K, Del Rio C, **Franco-Paredes C**. *Pneumocystis jiroveci* (PCP) in the Inner City: A Persistent and Deadly Pathogen. *Am J Med Sci* 2008; 335:192-197.
19. Rodriguez-Morales AJ, Olinda, **Franco-Paredes C**. Cutaneous Leishmaniasis Imported from Colombia to Northcentral Venezuela: Implications for Travel Advice. *Trav Med Infect Dis* 2008; 6(6): 376-9.
20. Jacob J, Kozarsky P, Dismukes R, Bynoe V, Margoles L, Leonard M, Tellez I, **Franco-Paredes C**. Five-Year Experience with Type 1 and Type 2 Reactions in Hansen's Disease at a US Travel Clinic. *Am J Trop Med Hygiene* 2008; 79:452-454.
21. Delgado O, Silva S, Coraspe V, Ribas MA, Rodriguez-Morales AJ, Navarro P, **Franco-Paredes C**. Epidemiology of Cutaneous Leishmaniasis in Children and Adolescents in Venezuela. *Trop Biomed.* 2008; 25(3):178-83.
22. **Franco-Paredes C**, Lammoglia L, Hernandez I, Santos-Preciado JI. Epidemiology and Outcomes of Bacterial Meningitis in Mexican Children: 10-Years' Experience (1993-2003). *Int J Infect Dis* 2008; 12:380-386.
23. Pedroza A, Huerta GJ, Garcia ML, Rojas A, Lopez I, Peñagos M, **Franco-Paredes C**, Deroche C, Mascareñas C. The Safety and Immunogenicity of Influenza Vaccine in Children with Asthma in Mexico. *Int J Infect Dis* 2009; 13(4): 469-75.
24. Museru O, **Franco-Paredes C**. Epidemiology and Outcomes of Hepatitis B Virus Infection among Refugees Seen at U.S. Travel Medicine Clinic: 2005-2008. *Travel Med Infect Dis* 2009; 7: 171-179.

25. Rodriguez-Morales AJ, Olinda M, **Franco-Paredes C**. Imported Cases of Malaria Admitted to Two Hospitals of Margarita Island, Venezuela: 1998-2005. *Travel Med Infect Dis* 2009; (1): 48-45.
26. Kelley CF, Checkley W, Mannino DM, **Franco-Paredes C**, Del Rio C, Holguin F. Trends in Hospitalizations for AIDS-associated *Pneumocystis jiroveci* Pneumonia in the United States (1986-2005). *Chest* 2009; 136(1): 190-7.
27. Carranza M, Newton O, **Franco-Paredes C**, Villasenor A. Clinical Outcomes of Mexican Children with Febrile Acute Upper Respiratory Infection: No Impact of Antibiotic Therapy. *Int J Infect Dis* 2010; 14(9): e759-63.
28. Museru O, Vargas M, Kinyua M, Alexander KT, **Franco-Paredes C**, Oladele A. Hepatitis B Virus Infection among Refugees Resettled in the U.S.: High Prevalence and Challenges in Access to Health Care. *J Immigrant Minor Health* 2010;
29. Moro P, Thompson B, Santos-Preciado JJ, Weniger B, Chen R, **Franco-Paredes C**. Needlestick injuries in Mexico City sanitation workers. *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* 2010; 27(6): 467-8.
30. Barragan M, Holtz M, **Franco-Paredes C**, Leonard M. The Untimely Misfortune of Tuberculosis Diagnosis at time of Death. *Infect Dis Clin Pract* 2010; 18(6):1-7.
31. Hochberg N, Armstrong W, Wang W, Sheth A, Moro R, Montgomery S, Steuer F, Lennox J, **Franco-Paredes C**. High Prevalence of Persistent Parasitic Infections in Foreign-born HIV-infected Persons in the United States. *PLoS Neglect Dis* 2011; 5(4): e1034.
32. Larocque RC, Rao SR, Lee J, Ansdell V, Yates JA, Schwartz BS, Knouse M, Cahill J, Hagmann S, Vinetz J, Connor BA, Goad JA, Oladele A, Alvarez S, Stauffer W, Walker P, Kozarsky P, **Franco-Paredes C**, Dismukes R, Rosen J, Hynes NA, Jacquerioz F, McLellan S, Hale D, Sofarelli T, Schoenfeld D, Marano N, Brunette G, Jentes ES, Yanni E, Sotir MJ, Ryan ET; the Global TravEpiNet Consortium. Global TravEpiNet: A National Consortium of Clinics Providing Care to International Travelers--Analysis of Demographic Characteristics, Travel Destinations, and Pretravel Healthcare of High-Risk US International Travelers, 2009-2011. *Clin Infect Dis*. 2012; 54(4):455-462.
33. Espinosa-Padilla SE, Murata C, Estrada-Parra S, Santos-Argumendo L, Mascarenas C, **Franco-Paredes C**, Espinosa-Rosales FJ. Immunogenicity of a 23-valent pneumococcal polysaccharide vaccine among Mexican children. *Arch Med Res* 2012;
34. Harris JR, Lockhart SR, Sondermeyer G, Vugia DJ, Crist MB, D'Angelo MT, Sellers B, **Franco-Paredes C**, Makvandi M, Smelser C, Greene J, Stanek D, Signs

- K, Nett RJ, Chiller T, Park BJ. *Cryptococcus gattii* infections in multiple states outside the US Pacific Northwest. *Emerg Infect Dis*. 2013; 19 (10):1620-6.
- 35. Franco-Paredes C.** Aerobic actinomycetes that masquerade as pulmonary tuberculosis. *Bol Med Hosp Infant Mex* 2014; 71(1): 36-40.
- 36. Chastain DB, Ngando I, Bland CM, Franco-Paredes C, and Hawkins WA.** Effect of the 2014 Clinical and Laboratory Standard Institute urine-specific breakpoints on cefazolin susceptibility rates at a community teaching hospital. *Ann Clin Microbiol Antimicrob* 2017; 16(1): 43.
- 37. Kashef Hamadani BH, Franco-Paredes C, MCollister B, Shapiro L, Beckham JD, Henao-Martinez AF.** Cryptococcosis and cryptococcal meningitis- new predictors and clinical outcomes at a United States Academic Medical Center. *Mycoses* 2017; doi: 10.1111/myc.12742.
- 38. Chastain DB, Franco-Paredes C, Wheeler SE, Olubajo B, Hawkins A.** Evaluating Guideline Adherence regarding Empirical Vancomycin use in patients with neutropenic fever. *Int J Infect Dis* 2018; Feb 22. pii: S1201-9712(18)30052-3. doi: 10.1016/j.ijid.2018.02.016. PMID: 29477362
- 39. Parra-Henao G, Amioka E, Franco-Paredes C, Colborn KL, Henao-Martinez AF.** Heart failure symptoms and ecological factors as predictors of Chagas disease among indigenous communities in the Sierra Nevada de Santa Marta, Colombia. *J Card Fail* 2018; Mar 26. pii: S1071-9164(18)30119-2. doi: 10.1016/j.cardfail.2018.03.007.
- 40. Vela Duarte D, Henao-Martinez AF, Nyberg E, Castellanos P, Franco-Paredes C, Chastain DB, Lacunar** Stroke in Cryptococcal Meningitis: Clinical and Radiographic Features. *J Stroke and Cerebrovascular Disease* 2019;
- 41. Chastain DB, Henao-Martinez AF, Franco-Paredes C.** A clinical pharmacist survey of prophylactic strategies used to prevent adverse events of lipid-associated formulations of amphotericin B. *Infect Dis* 2019;
- 42. Henao-Martínez AF, Chadawala S, Villamil-Gomez WE, DeSanto K, Rassi A Jr, Franco-Paredes C.** Duration and determinants of Chagas latency: an etiology and risk systematic review protocol. *JBIS Database System Rev Implement Rep*. 2019 Jul 22. doi: 10.11124/JBISRIR-D-18-00018.

CONSENSUS STATEMENTS

Pritchett MA, Oberg CL, Belanger A, De Cardenas J, Cheng G, Cumbo Nacheli G, **Franco-Paredes C**, Singh J, Toth J, Zgoda M, Folch E. Society for Advanced Bronchoscopy Consensus Statement and Guidelines for bronchoscopy and airway management amid the COVID-19 pandemic. *J Thorac Dis* 2020; <http://dx.doi.org/10.21037/jtd.2020.04.32>

RESEARCH ORIGINAL ARTICLES AS COLLABORATOR (clinical, basic science, other) in refereed journals:

43. Benator D, Bhattacharya M, Bozeman L, Burman W, Cantazaro A, Chaisson R, Gordin F, Horsburgh CR, Horton J, Khan A, Lahart C, Metchock B, Pachucki C, Stanton L, Vernon A, Villarino ME, Wang YC, Weiner M, Weis S; **Tuberculosis Trials Consortium**. Rifapentine and Isoniazid Once a Week versus Rifampicin and Isoniazid twice a week for Treatment of Drug-susceptible Pulmonary Tuberculosis in HIV-Negative Patients: a Randomised Clinical Trial. *Lancet* 2002; 360:528-34.
44. Weiner M, Burman W, Vernon A, Benator D, Peloquin CA, Khan A, Weis S, King B, Shah N, Hodge T; **Tuberculosis Trials Consortium**. Low INH Concentrations and Outcome of Tuberculosis Treatment with Once-weekly INH and Rifapentine. *Am J Rev Crit Care Med* 2003; 167:1341-1347.
45. Jasmer RM, Bozeman L, Schwartzman K, Cave MD, Saukkonen JJ, Metchock B, Khan A, Burman WJ; **Tuberculosis Trials Consortium**. **Recurrent Tuberculosis in the United States and Canada: Relapse or Reinfection?** *Am J Respir Crit Care Med* 2004; **170:1360-1366**.
- Mendelson M, Davis XM, Jensenius M, Keystone JS, von Sonnenburg F, Hale DC, Burchard GD, Field V, Vincent P, Freedman DO; **GeoSentinel Surveillance Network**. [Health risks in travelers to South Africa: the GeoSentinel experience and implications for the 2010 FIFA World Cup](#). *Am J Trop Med Hyg*. 2010; 82(6): 991-5.
46. Hagmann S, Neugebauer R, Schwartz E, Perret C, Castelli F, Barnett ED, Stauffer WM; GeoSentinel Surveillance Network. Illness in children after international travel: analysis from the **GeoSentinel Surveillance Network**. *Pediatrics*. 2010; 125(5): e1072-80.
47. Schlagenhauf P, Chen LH, Wilson ME, Freedman DO, Tcheng D, Schwartz E, Pandey P, Weber R, Nadal D, Berger C, von Sonnenburg F, Keystone J, Leder K; **GeoSentinel Surveillance Network**. Sex and gender differences in travel-associated disease. *Clin Infect Dis*. 2010; 50 (6): 826-32.
48. Jensenius M, Davis X, von Sonnenburg F, Schwartz E, Keystone JS, Leder K, Lopéz-Véléz R, Caumes E, Cramer JP, Chen L, Parola P; **GeoSentinel Surveillance Network**. Multicenter GeoSentinel analysis of rickettsial diseases in international travelers, 1996-2008. *Emerg Infect Dis*. 2009; 15(11):1791-8.
49. Chen LH, Wilson ME, Davis X, Loutan L, Schwartz E, Keystone J, Hale D, Lim PL, McCarthy A, Gkrania-Klotsas E, Schlagenhauf P; **GeoSentinel Surveillance Network**. *Emerg Infect Dis*. 2009; 15(11): 1773-82.
50. Nicolls DJ, Weld LH, Schwartz E, Reed C, von Sonnenburg F, Freedman DO, Kozarsky PE; **GeoSentinel Surveillance Network**. [Characteristics of](#)

[schistosomiasis in travelers reported to the GeoSentinel Surveillance Network 1997-2008](#). *Am J Trop Med Hyg* 2008; 79(5): 729-34.

51. Greenwood Z, Black J, Weld L, O'Brien D, Leder K, Von Sonnenburg F, Pandey P, Schwartz E, Connor BA, Brown G, Freedman DO, Torresi J; **GeoSentinel Surveillance Network**. Gastrointestinal infection among international travelers globally. *J Travel Med* 2008; 15(4):221-8.

52. Davis XM, MacDonald S, Borwein S, Freedman DO, Kozarsky PE, von Sonnenburg F, Keystone JS, Lim PL, Marano N; **GeoSentinel Surveillance Network**. [Health risks in travelers to China: the GeoSentinel experience and implications for the 2008 Beijing Olympics](#). *Am J Trop Med Hyg* 2008; 79(1): 4-8.

53. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Vaccine preventable diseases in returned international travelers: results from the GeoSentinel Surveillance Network. *Vaccine* 2010; 28(46):7389-95.

54. Esposito DH, Han PV, Kozarsky PE, Walker PF, Gkrania-Klotsas E, Barnett ED, Libman M, McCarthy AE, Field V, Connor BA, Schwartz E, MacDonald S, Sotir MJ; **GeoSentinel Surveillance Network**. Characteristics and spectrum of disease among ill returned travelers from pre- and post-earthquake Haiti: The GeoSentinel experience. *Am J Trop Med Hyg* 2012 Jan; 86(1):23-8.

55. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Latitudinal patterns of travel among returned travelers with influenza: results from the GeoSentinel Surveillance Network, 1997-2007. *J Travel Med* 2012; 19(1):4-8. doi: 10.1111/j.1708-8305.2011.00579.x.

REVIEW, EDITORIALS, CASE SERIES, CASE REPORT ARTICLES:

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J. Bello, **Carlos Franco-Paredes**, Juliana Buitrago, Marlen Martinez-Gutierrez, Julio Maquera-Afaray, Marco A. Solarte-Portilla, Sebastián Hernández-Botero, Krisell Contreras, Jaime A. Cardona-Ospina, D. Katterine Bonilla-Aldana, Alfonso J. Rodriguez-Morales. Infectious Diseases, Social, Economic and Political Crises, Anthropogenic Disasters and Beyond: Venezuela 2019-Implications for public health and travel medicine. *Rev Panam Enf Inf* 2018; 1(2):73-93.

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FORMAL TEACHING

Medical Student Teaching

2001 - 2002 Clinical Methods, Emory University School of Medicine

I. 2001 - 2002 Clinical Instructor Harvey Cardiology Course, Emory University School of Medicine

2001 - 2002 Problem-Based Learning for Second year Medical Students, EUSM

2005-2011 Clinical Methods Preceptor, ECLH

2006-2008 Medical Spanish - Instructor for M2, EUSM

2006-2007 Directed Study on Social Determinants of Infectious Diseases for M2 students (Lindsay Margolis and Jean Bendik), EUSM

- 2007-2011 Instructor - Global Health for M2 Students, EUSM
- 2007-2008 Presentation-Case Discussion – Social Determinants of Diseases – Coordinated by Dr. Bill Eley – Emory School of Medicine New Curriculum.
- 2018- Small Group: Parasitic Diseases, Microbiology Course for First Year Medical Students, University of Colorado, Anschutz Medical Center.
- 2019- MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite
- 2019- Class Global Health and Underserved Populations of the New SOM CU Curriculum. Course Co-Director. Pilot Class (Jan 6-Jan 17, 2020).
- 2020- MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite

Graduate Program

Training programs

- 2006-2011 Professor - GH511 (Global Health 511) International Infectious Diseases Prevention and Control, Rollins School of Public Health
- 2009-2011 Professor – GH500 D – Key Issues in Global Health, Career MPH Program
- 2006-2011 Thesis Advisor to students Global Health Track – Hubert Department of Global Health, Rollins School of Public Health of Emory University
- 2008-2011 Coordinator International Exchange between Rollins School of Public Health and National Institute of Public Health, Cuernavaca, Mexico – Supported by the Global Health Institute of Emory University

Residency and Fellowship Program:

- 2004-2011 Resident Report – Noon Conferences Emory Crawford Long Hospital and Grady Memorial Hospital
- 2004-2011 Didactic Lectures on Parasitic Diseases and Non-tuberculous mycobacterial diseases for Internal Medicine Residents and Infectious Disease Fellows

- 2005-2008 Coordinator Journal Club Infectious Disease Division
- 2005-2011 Travel Medicine Elective, Internal Medicine Residents (2 internal residents per month)
- 2005 Grand Rounds – EUH - Department of Medicine: “Travel Medicine”
- 2006 Grand Rounds – ECLH – Department of Medicine: “Malaria”
- 2008 Grand Rounds - ECLH – Department of Medicine: “Leprosy”
- 2008-2011 Journal Club Coordinator, Internal Medicine Residency Program – ECLH
- 2009 Grand Rounds - EUH – Department of Medicine: “Leprosy a Modern Perspective of an Ancient Disease”
- 2009 Grand Rounds – Pulmonary and Critical Care Division – Neglected Tropical Diseases of the Respiratory Tract, June 16, 2009
- 2017 Grand Rounds – Leprosy, University of Colorado, Anschutz Medical Center, Division of Infectious Diseases, December 2017
- 2017 Grand Rounds – Infections associated with Secondary Antiphospholid Syndrome, University of Colorado, Anschutz Medical Center, Division of Rheumatology,
- 2018 Didactic Session – Travel Medicine (Pretravel and Postravel) Infectious Diseases Fellowship Anschutz Medical Center, Division of Infectious Diseases
- 2017- Infectious Diseases Fellows Clinic, University of Colorado, Anschutz Medical Center, IDPG.
- 2019 Invited Speaker: Travel Medicine, Pretravel/Postravel Care, Physician Assistant Program, September 12, 2019, University of Colorado, Anschutz Medical Center

Other categories:

- 2000-2002 Physician Assistant Supervision during Fellowship/Junior Faculty, Emory University
- 2004-2007 Mentoring of four College Students to enter into Medical School (Emory, Southern University, and Dartmouth):
Lindsay Margolis 2004-Emory University

Michael Woodworth 2005 – Emory University

Peter Manyang 2007 – Southern University

Padraic Chisholm 2007 – Southern University/Emory University

2009-2011 Project Leader. Partnership – Emory Global Health Institute – University-wide - Emory Travel Well Clinic and is titled Hansen’s disease in the state of Georgia: A Modern Reassessment of an Ancient Disease”. <http://www.globalhealth.emory.edu/fundingOpportunities/projectideas.php>. Students: 5 MPH students (RN/MPH, MD/MPH)

2017- Infectious Diseases Fellowship Program, University of Colorado, Anschutz Medical Center. Teaching activities Inpatient and outpatient (ID Fellows Weekly Clinic)

2019- Infectious Diseases Fellowship Program Director University of Colorado, Aurora Colorado

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

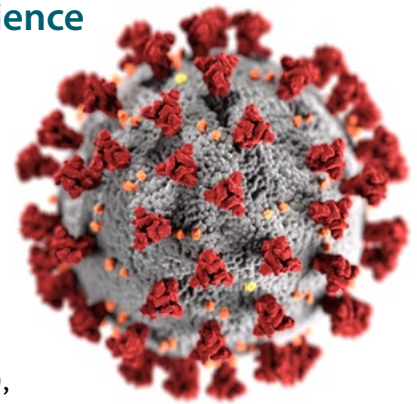
This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

In this guidance

- Who is the intended audience for this guidance?
- Why is this guidance being issued?
- What topics does this guidance include?
- Definitions of Commonly Used Terms
- Facilities with Limited Onsite Healthcare Services
- COVID-19 Guidance for Correctional Facilities
- Operational Preparedness
- Prevention
- Management
- Infection Control
- Clinical Care of COVID-19 Cases
- Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons
- Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

Who is the intended audience for this guidance?

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.



This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.



cdc.gov/coronavirus

Why is this guidance being issued?

Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community or other regions.
- Persons incarcerated/detained in a particular facility often come from a variety of locations, increasing the potential to introduce COVID-19 from different geographic areas.
- Options for medical isolation of COVID-19 cases are limited and vary depending on the type and size of facility, as well as the current level of available capacity, which is partly based on medical isolation needs for other conditions.
- Adequate levels of custody and healthcare staffing must be maintained to ensure safe operation of the facility, and options to practice social distancing through work alternatives such as working from home or reduced/alternate schedules are limited for many staff roles.
- Correctional and detention facilities can be complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. Similarly, correctional and detention facilities may house individuals from multiple law enforcement agencies or jurisdictions subject to different policies and procedures.
- Incarcerated/detained persons and staff may have [medical conditions that increase their risk of severe disease from COVID-19](#).
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for COVID-19 spread may be high, potentially creating security and morale challenges.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and is determined by the supplies provided in the facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.
- Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

CDC has issued separate COVID-19 guidance addressing [healthcare infection control](#) and [clinical care of COVID-19 cases](#) as well as [close contacts of cases](#) in community-based settings. Where relevant, community-focused guidance documents are referenced in this document and should be monitored regularly for updates, but they may require adaptation for correctional and detention settings.

This guidance document provides additional recommended best practices specifically for correctional and detention facilities. **At this time, different facility types (e.g., prison vs. jail) and sizes are not differentiated. Administrators and agencies should adapt these guiding principles to the specific needs of their facility.**

What topics does this guidance include?

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- ✓ Operational and communications preparations for COVID-19
- ✓ Enhanced cleaning/disinfecting and hygiene practices
- ✓ Social distancing strategies to increase space between individuals in the facility
- ✓ How to limit transmission from visitors
- ✓ Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- ✓ Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- ✓ Medical isolation of confirmed and suspected cases and quarantine of contacts, including considerations for cohorting when individual spaces are limited
- ✓ Healthcare evaluation for suspected cases, including testing for COVID-19
- ✓ Clinical care for confirmed and suspected cases
- ✓ Considerations for persons at higher risk of severe disease from COVID-19

Definitions of Commonly Used Terms

Close contact of a COVID-19 case—In the context of COVID-19, an individual is considered a close contact if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) have had direct contact with infectious secretions from a COVID-19 case (e.g., have been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

Cohorting—Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative. See [Quarantine](#) and [Medical Isolation](#) sections below for specific details about ways to implement cohorting to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19—Community transmission of COVID-19 occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls. Facilities should consult with local public health departments if assistance is needed in determining how to define “local community” in the context of COVID-19 spread. However, because all states have reported cases, all facilities should be vigilant for introduction into their populations.

Confirmed vs. Suspected COVID-19 case—A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Incarcerated/detained persons—For the purpose of this document, “incarcerated/detained persons” refers to persons held in a prison, jail, detention center, or other custodial setting where these guidelines are generally applicable. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e., detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Medical Isolation—Medical isolation refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials (detailed in guidance [below](#)). In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term “medical isolation” to avoid confusion.

Quarantine—Quarantine refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. Ideally, each quarantined individual would be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, the individual should be placed under [medical isolation](#) and evaluated for COVID-19. If symptoms do not develop, movement restrictions can be lifted, and the individual can return to their previous residency status within the facility.

Social Distancing—Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this [CDC publication](#).

Staff—In this document, “staff” refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g., private healthcare or food service). Except where noted, “staff” does not distinguish between healthcare, custody, and other types of staff including private facility operators.

Symptoms—[Symptoms of COVID-19](#) include fever, cough, and shortness of breath. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the [CDC website](#) for updates on these topics.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails usually employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of confirmed and suspected COVID-19 cases and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they encounter confirmed or suspected cases among incarcerated/detained persons or staff, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on [recommended PPE](#) in order to ensure their own safety when interacting with confirmed and suspected COVID-19 cases. Facilities should make contingency plans for the likely event of [PPE shortages](#) during the COVID-19 pandemic.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness.** This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention.** This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening (new intakes, visitors, and staff), continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).
- **Management.** This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the [symptoms of COVID-19](#) and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication & Coordination

✓ **Develop information-sharing systems with partners.**

- Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
 - Where possible, put plans in place with other jurisdictions to prevent [confirmed and suspected COVID-19 cases and their close contacts](#) from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
 - Stay informed about updates to CDC guidance via the [CDC COVID-19 website](#) as more information becomes known.
- ✓ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**
- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See [Medical Isolation](#) and [Quarantine](#) sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
 - [Facilities without onsite healthcare capacity](#) should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
 - Make a list of possible [social distancing strategies](#) that could be implemented as needed at different stages of transmission intensity.
 - Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.
- ✓ **Coordinate with local law enforcement and court officials.**
- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
 - Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.
- ✓ **Post [signage](#) throughout the facility communicating the following:**
- **For all:** symptoms of COVID-19 and hand hygiene instructions
 - **For incarcerated/detained persons:** report symptoms to staff
 - **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow [CDC-recommended steps for persons who are ill with COVID-19 symptoms](#) including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
 - Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

- ✓ **Review the sick leave policies of each employer that operates in the facility.**
- Review policies to ensure that they actively encourage staff to stay home when sick.
 - If these policies do not encourage staff to stay home when sick, discuss with the contract company.
 - Determine which officials will have the authority to send symptomatic staff home.

- ✓ **Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.**
 - Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
 - Put systems in place to implement work from home programs (e.g., time tracking, etc.).
- ✓ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
 - Allow staff to work from home when possible, within the scope of their duties.
 - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
 - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
 - Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.
- ✓ **Consider offering revised duties to staff who are at [higher risk of severe illness with COVID-19](#).** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See [CDC's website](#) for a complete list, and check regularly for updates as more data become available to inform this issue.
 - Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- ✓ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.
- ✓ **Reference the [Occupational Safety and Health Administration website](#) for recommendations regarding worker health.**
- ✓ **Review [CDC's guidance for businesses and employers](#)** to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

- ✓ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
 - Standard medical supplies for daily clinic needs
 - Tissues
 - Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
 - Hand drying supplies
 - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
 - Cleaning supplies, including [EPA-registered disinfectants effective against the virus that causes COVID-19](#)

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See [PPE section](#) and [Table 1](#) for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs [to collect nasopharyngeal specimens](#) if COVID-19 testing is indicated
- ✓ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
 - See CDC guidance [optimizing PPE supplies](#).
- ✓ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, [CDC recommends](#) cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
- ✓ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See [Hygiene](#) section below for additional detail regarding recommended frequency and protocol for hand washing.)
 - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
- ✓ **If not already in place, employers operating within the facility should establish a [respiratory protection program](#) as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
- ✓ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See [Table 1](#) for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

Operations

- ✓ **Stay in communication with partners about your facility's current situation.**
 - State, local, territorial, and/or tribal health departments
 - Other correctional facilities
- ✓ **Communicate with the public about any changes to facility operations, including visitation programs.**

- ✓ **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
 - Strongly consider postponing non-urgent outside medical visits.
 - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the [Screening](#) section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the [protocol for a suspected COVID-19 case](#)—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see [Table 1](#)) and that the transport vehicle is [cleaned](#) thoroughly after transport.
- ✓ **Implement lawful alternatives to in-person court appearances where permissible.**
- ✓ **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.**
- ✓ **Limit the number of operational entrances and exits to the facility.**

Cleaning and Disinfecting Practices

- ✓ **Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.**
- ✓ **Adhere to [CDC recommendations for cleaning and disinfection during the COVID-19 response](#).** Monitor these recommendations for updates.
 - Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
 - Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
 - Use household cleaners and [EPA-registered disinfectants effective against the virus that causes COVID-19](#) as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants.
 - Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.
- ✓ **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**
- ✓ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

- ✓ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- ✓ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis. [Sample signage and other communications materials](#) are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
 - **Practice good [cough etiquette](#):** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
 - **Practice good [hand hygiene](#):** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
 - **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
 - **Avoid sharing eating utensils, dishes, and cups.**
 - **Avoid non-essential physical contact.**
- ✓ **Provide incarcerated/detained persons and staff no-cost access to:**
 - **Soap**—Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
 - **Running water, and hand drying machines or disposable paper towels for hand washing**
 - **Tissues** and no-touch trash receptacles for disposal
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- ✓ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- ✓ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See [Screening section](#) below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see [PPE section](#) below).
 - **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
 - Require the individual to wear a face mask.
 - Ensure that staff who have direct contact with the symptomatic individual wear [recommended PPE](#).
 - Place the individual under [medical isolation](#) (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See [Infection Control](#) and [Clinical Care](#) sections below.)
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

○ **If an individual is a [close contact](#) of a known COVID-19 case (but has no COVID-19 symptoms):**

- Quarantine the individual and monitor for symptoms two times per day for 14 days. (See [Quarantine](#) section below.)
- Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

✓ **Implement [social distancing](#) strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

○ **Common areas:**

- Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)

○ **Recreation:**

- Choose recreation spaces where individuals can spread out
- Stagger time in recreation spaces
- Restrict recreation space usage to a single housing unit per space (where feasible)

○ **Meals:**

- Stagger meals
- Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
- Provide meals inside housing units or cells

○ **Group activities:**

- Limit the size of group activities
- Increase space between individuals during group activities
- Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
- Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out

○ **Housing:**

- If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are [cleaned](#) thoroughly if assigned to a new occupant.)
- Arrange bunks so that individuals sleep head to foot to increase the distance between them
- Rearrange scheduled movements to minimize mixing of individuals from different housing areas

○ **Medical:**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
- Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

- ✓ **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**
- ✓ **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**
- ✓ **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- ✓ **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis, including:**
 - Symptoms of COVID-19 and its health risks
 - Reminders to report COVID-19 symptoms to staff at the first sign of illness
- ✓ **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

Prevention Practices for Staff

- ✓ **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- ✓ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
 - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
 - Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- ✓ **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
 - Symptoms of COVID-19 and its health risks
 - Employers' sick leave policy
 - **If staff develop a fever, cough, or shortness of breath while at work:** immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
 - **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
 - **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- ✓ **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
 - Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).

- ✓ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**
- ✓ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

- ✓ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- ✓ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See [Screening](#) section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
 - Staff performing temperature checks should wear [recommended PPE](#).
 - Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- ✓ **Provide visitors and volunteers with information to prepare them for screening.**
 - Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
 - If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
 - Display [signage](#) outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- ✓ **Promote non-contact visits:**
 - Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
 - Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
 - Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- ✓ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
 - If moving to virtual visitation, clean electronic surfaces regularly. (See [Cleaning](#) guidance below for instructions on cleaning electronic surfaces.)
 - Inform potential visitors of changes to, or suspension of, visitation programs.
 - Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
 - If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health.

If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

- ✓ **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

Management

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Operations

- ✓ **Implement alternate work arrangements deemed feasible in the [Operational Preparedness](#) section.**
- ✓ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**
 - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the [Screening](#) section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the [protocol for a suspected COVID-19 case](#)—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see [Table 1](#)) and that the transport vehicle is [cleaned](#) thoroughly after transport.
- ✓ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.
- ✓ **When possible, arrange lawful alternatives to in-person court appearances.**
- ✓ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**
 - Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See [Screening](#) section below.)
 - If an individual does not clear the screening process, follow the [protocol for a suspected COVID-19 case](#)—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
 - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
 - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

✓ **Coordinate with state, local, tribal, and/or territorial health departments.**

- When a COVID-19 case is suspected, work with public health to determine action. See [Medical Isolation](#) section below.
- When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See [Quarantine](#) section below.
- Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See [Facilities with Limited Onsite Healthcare Services](#) section.

Hygiene

- ✓ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See [above](#).)
- ✓ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See [above](#).)

Cleaning and Disinfecting Practices

- ✓ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See [above](#).)
- ✓ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time ([below](#)).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. [Facilities with Limited Onsite Healthcare Services](#), or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that COVID-19 cases will be appropriately isolated, evaluated, tested (if indicated), and given care.

- ✓ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**
- ✓ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**
 - Provide medical care to cases inside the medical isolation space. See [Infection Control](#) and [Clinical Care](#) sections for additional details.
 - Serve meals to cases inside the medical isolation space.
 - Exclude the individual from all group activities.
 - Assign the isolated individual a dedicated bathroom when possible.
- ✓ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.
- ✓ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** [Cohorting](#) should only be practiced if there are no other available options.

- If cohorting is necessary:
 - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
 - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.
 - Ensure that cohorted cases wear face masks at all times.

✓ **In order of preference, individuals under medical isolation should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ [social distancing strategies related to housing in the Prevention section above](#).
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ [social distancing strategies related to housing in the Prevention section above](#).
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ [social distancing strategies related to housing in the Prevention section above](#).
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

✓ **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of [cases who are at higher risk of severe illness from COVID-19](#).** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See [CDC's website](#) for a complete list, and check regularly for updates as more data become available to inform this issue.
- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

✓ **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see [PPE](#) section below) and should limit their own movement between different parts of the facility to the extent possible.

✓ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**

- ✓ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:
 - **Cover** their mouth and nose with a tissue when they cough or sneeze
 - **Dispose** of used tissues immediately in the lined trash receptacle
 - **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that [hand washing supplies](#) are continually restocked.
- ✓ **Maintain medical isolation until all the following criteria have been met. Monitor the [CDC website](#) for updates to these criteria.**

For individuals who will be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

For individuals who will NOT be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- At least 7 days have passed since the first symptoms appeared

For individuals who had a confirmed positive COVID-19 test but never showed symptoms:

- At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
- The individual has had no subsequent illness

- ✓ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**
 - If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the [Definitions](#) section for the distinction between confirmed and suspected cases.

- Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult [CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions](#)), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in [Prevention](#) section).

✓ **Hard (non-porous) surface cleaning and disinfection**

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
 - Consult a [list of products that are EPA-approved for use against the virus that causes COVID-19](#). Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
 - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
 - 5 tablespoons (1/3rd cup) bleach per gallon of water or
 - 4 teaspoons bleach per quart of water

✓ **Soft (porous) surface cleaning and disinfection**

- For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
 - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
 - Otherwise, use products [that are EPA-approved for use against the virus that causes COVID-19](#) and are suitable for porous surfaces.

✓ **Electronics cleaning and disinfection**

- For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics.
 - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on [CDC's website](#).

✓ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See [PPE](#) section below.)

✓ **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

✓ **[Laundry from a COVID-19 cases](#) can be washed with other individuals' laundry.**

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- ✓ **Consult [cleaning recommendations above](#) to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. [Facilities without onsite healthcare capacity](#), or without sufficient space to implement effective quarantine, should coordinate with local public health officials to ensure that close contacts of COVID-19 cases will be effectively quarantined and medically monitored.

- ✓ **Incarcerated/detained persons who are close contacts of a [confirmed or suspected COVID-19 case](#) (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**
 - If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.
- ✓ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is [considered a close contact](#) if they:**
 - Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
 - Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

- ✓ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**
 - Provide medical evaluation and care inside or near the quarantine space when possible.
 - Serve meals inside the quarantine space.
 - Exclude the quarantined individual from all group activities.
 - Assign the quarantined individual a dedicated bathroom when possible.
- ✓ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually. [Cohorting](#) multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.**
 - If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under [medical isolation](#) immediately.
 - If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
 - Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

- If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.

✓ **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of [those who are at higher risk of severe illness from COVID-19](#).** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify [social distancing strategies](#) for higher-risk individuals.)

✓ **In order of preference, multiple quarantined individuals should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ [social distancing strategies related to housing in the Prevention section](#) to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). [Employ social distancing strategies related to housing in the Prevention section above](#) to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements

(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

✓ **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see [PPE](#) section and [Table 1](#)):

- If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
- If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
- All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
- Asymptomatic individuals under [routine intake quarantine](#) (with no known exposure to a COVID-19 case) do not need to wear face masks.

✓ **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see [PPE](#) section and [Table 1](#)).

- Staff supervising asymptomatic incarcerated/detained persons under [routine intake quarantine](#) (with no known exposure to a COVID-19 case) do not need to wear PPE.

- ✓ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
 - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See [Medical Isolation](#) section above.)
 - See [Screening](#) section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- ✓ **If an individual who is part of a quarantined cohort becomes symptomatic:**
 - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
 - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
 - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- ✓ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- ✓ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- ✓ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- ✓ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
 - Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
 - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
 - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
 - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that suspected COVID-19 cases will be effectively isolated, evaluated, tested (if indicated), and given care.

- ✓ **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- ✓ **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See [Medical Isolation](#) section above.**

- ✓ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on [evaluation](#) and [testing](#). See [Infection Control](#) and [Clinical Care](#) sections below as well.
- ✓ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
 - If the COVID-19 test is positive, continue medical isolation. (See [Medical Isolation](#) section above.)
 - If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

- ✓ **Provide [clear information](#) to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
 - Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
 - Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- ✓ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See [Screening](#) section for a procedure to safely perform a temperature check.
- ✓ **Consider additional options to intensify [social distancing](#) within the facility.**

Management Strategies for Staff

- ✓ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
 - Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- ✓ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
 - See [above](#) for definition of a close contact.
 - Refer to [CDC guidelines](#) for further recommendations regarding home quarantine for staff.

Infection Control

Infection control guidance below is applicable to all types of correctional facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with confirmed or suspected COVID-19 cases.

- ✓ **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the [CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#). Monitor these guidelines regularly for updates.**

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- ✓ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see [PPE](#) section).
- ✓ **Refer to [PPE](#) section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

- ✓ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**
 - If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
 - The initial medical evaluation should determine whether a symptomatic individual is at [higher risk for severe illness from COVID-19](#). Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See [CDC's website](#) for a complete list, and check regularly for updates as more data become available to inform this issue.
- ✓ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the [CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease \(COVID-19\)](#) and monitor the guidance website regularly for updates to these recommendations.**
- ✓ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing [recommended PPE](#) and ensuring that the suspected case is wearing a face mask.**
 - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.
- ✓ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**
- ✓ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**
- ✓ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

- ✓ **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's [respiratory protection program](#).
- For PPE training materials and posters, please visit the [CDC website on Protecting Healthcare Personnel](#).

- ✓ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- ✓ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see [Table 1](#)). Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**
- ✓ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**
- ✓ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see [Table 1](#)). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**

See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.

- **Face mask**
- **Eye protection**—goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**

Gloves should be changed if they become torn or heavily contaminated.

- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**

- If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
- If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.

- ✓ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**

- [Guidance in the event of a shortage of N95 respirators](#)

- Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.

- [Guidance in the event of a shortage of face masks](#)

- [Guidance in the event of a shortage of eye protection](#)

- [Guidance in the event of a shortage of gowns/coveralls](#)

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✓
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

✓ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**

- *Today or in the past 24 hours, have you had any of the following symptoms?*
 - *Fever, felt feverish, or had chills?*
 - *Cough?*
 - *Difficulty breathing?*
- *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*

✓ **The following is a protocol to safely check an individual's temperature:**

- Perform hand hygiene
- Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
- Check individual's temperature
- **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be [cleaned routinely as recommended by CDC for infection control](#).
- Remove and discard PPE
- Perform hand hygiene

March 25, 2020

Hon. Larry Hogan
Governor of Maryland
Annapolis, MD

Dear Governor Hogan:

We are writing as faculty members of the Johns Hopkins Bloomberg School of Public Health, School of Nursing and School of Medicine to express our urgent concern about the spread of COVID-19 in Maryland's prisons, jails, and juvenile detention centers. As you know, COVID-19 is highly contagious, difficult to prevent except through social distancing, and especially dangerous to individuals over age 60 or with a chronic disease. Moreover, recent data suggest that the virus can remain on surfaces for up to 72 hours, thus rendering social distancing less effective in circumstances where the virus is present.

Jails, prisons, detention facilities and other closed settings have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, influenza, MRSA (methicillin resistant staph aureus), and viral hepatitis. Several deaths were reported in the US in immigration detention facilities associated with ARDS (acute respiratory distress syndrome) following influenza A, including a 16 year old immigrant child who died of untreated ARDS in custody in May 2019. ARDS is the life-threatening complication of COVID-19 disease and has a 30% mortality given ideal care. A correctional officer in New York has also died of the disease.

The close quarters of jails and prisons, the inability to employ effective social distancing measures, and the many high-contact surfaces within facilities, make transmission of COVID-19 more likely. Soap and hand sanitizers are not freely available in some facilities. Hand sanitizers like Purell, are banned in many facilities, because they contain alcohol. Further, for incarcerated individuals who are infected or very sick, the ability properly to treat them and save their lives is very limited. Testing kits are in short supply, and prisons and jails have limited options for proper respiratory isolation.

A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of COVID-19 and other infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilets, showers, and eating environments and limited availability of hygiene and personal protective equipment such as masks and gloves in some facilities. The high rate of turnover and population mixing of staff and detainees also increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff.

These populations are also at additional risk, due to high rates of chronic health conditions; substance use; mental health issues; and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after COVID-19 infection, and to death. Given that Maryland prisons, jails, and juvenile detention centers incarcerate high

numbers of marginalized populations and African Americans will be disproportionately affected by these risks.

Prison, jail, and detention center staff may bring the virus into the facility and are also at risk of acquisition from infected incarcerated individuals. Once infected, staff may also transmit the virus back into the communities and to their families. As jail, prison, and detention center health care staff themselves get sick with COVID-19, workforce shortages will make it even more difficult to adequately address all the health care needs in facilities.

Every effort should be made to reduce exposure in jails and other detention facilities, and we appreciate the efforts thus far of administrators toward this goal. To ensure that there are no impediments for inmates to come forward when sick, health care must be available to inmates without co-pays. But there should also be efforts to reduce the state prison population as well. It may be extremely difficult, however, to achieve and sustain prevention of transmission in these closed settings and given the design feature of the facilities. Moreover, lockdowns and use of solitary confinement should not be used as a public health measure, both because they have limited effectiveness and because they are a severe infringement of the rights of incarcerated people. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

Treatment needs of infected incarcerated individuals also need to be met, including expanded arrangements with local hospitals. It is essential that these facilities, which are public institutions, be transparent about their plans for addressing COVID-19. Such transparency will help public health officials and families of incarcerated people know what facilities are doing, and it also can help jurisdictions across the state share information and best practices. Other counties across the country have shared their action plans with the public and Maryland should follow these examples.

We therefore urge you to take the following steps:

1. Require correctional facility administrators to make their plans for prevention and management of COVID-19 in their institutions publicly available, as the San Francisco Sheriff's Department has done. Protocols should be in line with national CDC guidance. Frequently updated recommendations and model protocols are available from the National Commission on Correctional Health Care (<https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections>)
2. Ensure that intake screening protocols are updated to include COVID-specific questions.
3. Ensure the availability of sufficient soap and hand sanitizer for incarcerated individuals without charge; restrictions on alcohol (in hand sanitizers) should be suspended.
4. Implement other precautions to limit transmission within prisons and jails without relying on widespread use of lockdowns and solitary confinement. Additional precautions jointly issued by the Vera Institute of Justice and Community Oriented

- Correctional Health Services are available at <https://cochs.org/files/covid-19/covid-19-jails-prison-immigration.pdf>
5. Consider pre-trial detention only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, or parole or probation violations, should be prioritized for release. No one in these categories should be sent to jail
 6. Expedite consideration of all older incarcerated individuals and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) for parole or other form of release from prison, with alternative forms of supervision and with supports in the community once released. Clemency power and expanded authority in Maryland law for administrative parole should be employed.
 7. Invest in increased resources for discharge planning and re-entry transitions to facilitate prison release of people under these revised policies.
 8. Arrange for COVID-19 testing of incarcerated individuals and correctional facility workers who become ill.
 9. Cease any collection of fees or co-pays or medical care.
 10. Seek a Medicaid 1135 waiver to enable hospitals to provide an appropriate level of care to incarcerated individuals who are sick. See <https://cochs.org/files/medicaid/COVID-19-Justice-Involved-1135-Waiver.pdf>

This pandemic is shedding a bright light on the extent of the connection between all members of society: jails, prisons and other detention facilities are not separate, but are fully integrated with our community. As public health experts, we believe these steps are essential to support the health of incarcerated individuals, who are some of the most vulnerable people in our society; the vital personnel who work in prisons and jail; and all people in the state of Maryland. Our compassion for and treatment of these populations impact us all.

Thank you very much.

This letter represents the views of the following signatories, and do not necessarily reflect the views of The Johns Hopkins University

Sincerely,

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Doctors in NYC Hospitals, Jails, and Shelters Call on the City to Take More Aggressive Action to Combat the Spread of Coronavirus



Brad Lander

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Mar 12 · 3 min read

From NYC Council Members Brad Lander and Ritchie Torres:



As public representatives, we have been talking with constituents, public health experts, schools, and city officials about how to balance the urgent need to slow the spread of coronavirus with the need to continue providing services, maintain public order, and lessen the hardships on families and vulnerable populations. In that spirit, we are sharing the following letter, provided to us by a group of doctors working in the City's hospitals, jails, clinics and shelters, which calls for the City to rapidly take far more aggressive steps (as they term it: "enforced solidarity") to halt community spread.

March 12, 2020

An Open Letter to Mayor de Blasio and City Officials

As doctors and public health officials working in the City's hospitals, jails, clinics, and shelters, we are extremely anxious about the impact of the COVID-19 virus on vulnerable populations and by the City's hesitance to take more dramatic action. Given the information we have about the exponential growth of the virus and the limited capacity of our health system to care for the number of people who will become sick and need care at the same time, we believe that aggressive measures must be taken now. Actions taken now to encourage and facilitate what we are calling enforced solidarity (a more accurate description than social distancing) will mitigate the impact of the virus on vulnerable populations and our health system.

We call on the City to:

Act immediately and boldly to slow the spread of the virus:

- Suspend classes at public schools, while keeping schools open for emergency childcare for essential workers and vulnerable families. Keep childcare groups small, under 10 kids per group. Close schools immediately and reopen some as centers of family support and mitigation.
- Order the NYPD to stop making low level arrests for violations and misdemeanors, in order to prevent the spread of the virus through our jails, courts, and precincts.

- Order the courts to consider release for anyone in pretrial detention over 60. Administratively reschedule all criminal court proceedings for people who are not currently incarcerated. Reschedule all other court proceedings.
- Urge businesses to have all non-essential workers work from home. Employers may have discretion over who is “essential,” but give guidance that only those providing services that must be maintained during a state of emergency should be considered essential.
- Strongly advise people over 60 to avoid public transit.
- Cancel all City events and revoke permits for events.
- Ensure that medical personnel have adequate personal protective equipment.
- Open a virus hotline for residents to be able to call a nurse and get a home visit if needed for quarantined people with moderate symptoms rather than bring people into the ER.
- Order the Administration of Children’s Services (ACS) to stop requiring parents to attend groups and programs; halt non-emergency family court proceedings, guarantee tele-visitation for parents and children.

Take steps to strengthen the social safety net to protect vulnerable New Yorkers.

- Turn schools into centers for community aid: food pantry, crisis navigation, and eventually satellite testing sites once we have capacity to test widely.
- Urge the State to adopt paid sick leave for up to 2 weeks for all workers immediately.
- Work with the State to institute an immediate moratorium on evictions and provide benefits for families and businesses.
- Divert workers from other non-essential services to Naturally Occurring Retirement Communities and public housing to check on quarantined elderly. Can do by phone/remote to minimize unnecessary contact.
- Increase Meals-on-Wheels service.

- Increase staffing for the City's mental health hotline to deal with increased anxiety and suicidality exacerbated by isolation and uncertainty.
- Take steps to address the digital divide, including providing burner cell phones at crisis centers and shelters for people who do not have cell phones.

We are grateful for the City's caution and attention to the impact of the coronavirus and associated response on vulnerable populations. We urge the City to begin taking more aggressive steps to shut down business as usual to slow community spread, while also increasing support for vulnerable populations.

Sincerely,

Doctors and public health officials working in NYC's hospitals, jails, clinics, and shelters

Healthcare Jail Shelter Doctors

About Help Legal

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

COREAS, et al.,

Petitioners-Plaintiffs,

v.

BOUNDS, et al,

Respondents-Defendants.

Civil Action No.:

DECLARATION OF Ranit Mishori, MD, MHS, FAAFP

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

I. Background

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and Professor of Family Medicine at the Georgetown University School of Medicine, where I am the director of the department's Global Health Initiatives, Health Policy fellowship and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master's degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).

2. I am the faculty leader for Georgetown University School of Medicine's Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons and detention centers. In addition, I am the director of Georgetown University's Asylum program which focuses on the care and medico-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.¹

3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants and refugees. I routinely come in contact with victims of abuse, trauma and poverty where I regularly assess their medical as well as psycho-social needs in the context of their social-determinants of health (such as housing and incarceration).

¹ See, e.g., Ranit Mishori, *Risk Behind Bars: Coronavirus and Immigration Detention*, The Hill (Mar. 17, 2020), <https://thehill.com/opinion/immigration/487986-risk-behind-bars-coronavirus-and-immigration-detention>; Amanda Holpuch, *Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say*, The Guardian (Mar. 11, 2020), <https://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers>; Abigail Hauslohner, et al., *Coronavirus Could Pose Serious Concern in ICE Jails, Immigration Courts*, The Washington Post (Mar. 12, 2020), https://www.washingtonpost.com/immigration/coronavirus-immigration-jails/2020/03/12/44b5e56a-646a-11ea-845d-e35b0234b136_story.html; Silvia Foster-Frau, *Coronavirus Cases in Migrant Detention Facilities Called 'Inevitable'*, Express News (Mar. 15, 2020) <https://www.expressnews.com/news/us-world/border-mexico/article/Whether-in-detention-or-in-Mexico-U-S-15129447.php>.

4. For four years I was an elected member of the American Academy of Family Physicians' Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a one of the lead authors of the Academy's comprehensive position paper on Incarceration and Health.

5. My CV is attached as Exhibit A.

II. COVID-19

6. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. COVID-19 has now reached pandemic status. As of March 24, 2020, according to the World Health Organization (WHO), more than 334,000 people have been diagnosed with COVID-19 around the world and 14,652 have died.² In the United States, about 31,537 people have been diagnosed and more than 400 people have died as of the same date.³ The numbers of infection and death in the United States are likely underestimated due to the lack of test kits available.

7. The transmission of Coronavirus is expected to grow exponentially. Nationally, projections by the Centers for Disease Control and Prevention (CDC) indicate that over 200 million people in the United States could be infected with Coronavirus over the course of the pandemic without effective public health intervention, with as many as 1.5 million deaths in certain projections.

² See Novel Coronavirus (COVID-19) Situation, World Health Organization, <https://experience.arcgis.com/experience/685d0ace521648f8a5beeee1b9125cd>, accessed Mar. 18, 2020 (at noon EDT).

³ See Mitch Smith, et al., *U.S. Coronavirus Map: Cases Now Reported in All 50 States*, The New York Times, <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1>, accessed Mar. 18, 2020 (at noon EDT).

8. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but it also survives on surfaces for some period of time. The virus can cause severe damage to lung tissue, requiring an extensive period of rehabilitation, and in some cases, a permanent loss of respiratory capacity. The virus also targets the heart muscle, leading to myocarditis, or inflammation of the heart muscle. 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 Coronavirus originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. The “contagiousness” of this novel coronavirus—its R_0 (the number of people who can get infected from a single infected person)—is twice that of the flu. 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. For this reason, only with aggressive testing for the virus can we track the disease, isolate those affected, and stop its spread.

9. COVID-19 is a serious disease, which can lead to respiratory failure, kidney failure, and death. Older patients and patients with chronic underlying conditions are at a particularly high risk for severe cases and complications.⁴ The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.

⁴ Fei Zhou, et al., *Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China*, The Lancet (published online Mar. 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).

According to preliminary data from China, serious illness, sometimes resulting in death, occurs in up to 16% of cases, with a higher rate among those older and high-risk individuals.⁵

10. The CDC previously identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including: blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

11. Those in high-risk categories who do not die may have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are likely to soon be in very short supply, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians. 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. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.

12. Complications from COVID-19, including severe damage to lung, heart, liver, or other organs, can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.

13. There is no vaccine to prevent COVID-19. There is no known cure or antiviral treatment for COVID-19 at this time.

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

14. COVID-19 prevention strategies include containment and mitigation. Containment requires identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Unfortunately, due to the lack of testing availability, most public health experts agree that it is too late to effectively implement a containment strategy in the United States at-large.

15. As the infectious disease spreads in a community, public health demands mitigation strategies, which include scrupulous hand hygiene and social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of coronavirus. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of this risk mitigation strategy.

III. Detention Centers, Jails, & Prisons

16. The risk posed by infectious diseases in immigration detention facilities, including jails and prisons, is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

17. Globally, outbreaks of contagious diseases are all too common in confined detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. ICE has temporarily suspended social visitation in all detention facilities.⁶ However, staff arrive and leave on a shift basis; there is no ability to adequately screen staff for new, asymptomatic infection. Contractors and vendors

⁶ *ICE Guidance on Covid-19*, U.S. Immigration and Customs Enforcement, accessed Mar. 18, 2020 (at 1:00 p.m. EDT), <https://www.ice.gov/covid19>.

also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities.

18. Jails, prisons and detention centers often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits.

19. During an infectious disease outbreak, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Jails and prisons are often under-resourced and ill-equipped to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak. Moreover, efforts to mitigate disease spread in jails, prisons and detention centers will help limit its transmission in the community, since staff members are able to come and go, and return to their family members at the end of their shifts. This is especially true when, as now, facemasks are already in short supply.

20. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. 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 live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. Toilets, sinks, and showers are shared, without disinfection between use. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world—including

their family and lawyers. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

21. Additionally, jails and prisons are often unable to adequately provide the mitigation recommendations described above. During an infectious disease outbreak, people can protect themselves by washing hands. Detention centers, 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 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.

22. People incarcerated in detention centers, jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.⁷ This is because people in detention centers, jails and prisons, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and suppressed immune systems from HIV or other conditions, than people in the community.

23. Detention centers, jails and prisons are often poorly equipped to manage infectious disease outbreaks. Some detention centers, jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at detention centers, jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of

⁷ *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).

droplet-borne infectious diseases, people who are infected and symptomatic need to be isolated in specialized negative pressure rooms. Most detention centers, 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). ICE has admitted that not all of the detention centers it oversees have even one.⁸ In the course of an infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.

24. Even assuming adequate space, solitary confinement is not an effective disease containment strategy. Isolation of people who are ill using solitary confinement is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms, 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 the staff. This makes both containing the illness and caring for those who have become infected much more difficult.

25. Infectious disease outbreaks, such as COVID-19, may exacerbate existing mental health conditions and contribute to the development of new mental health conditions.⁹ Mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. Moreover, failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by an infectious

⁸ Brittny Mejia, *ICE Says No Confirmed Coronavirus Among Detainees After 4 Test Negative*, Los Angeles Times, accessed Mar. 18, 2020, <https://www.latimes.com/california/story/2020-03-10/ice-says-no-detainees-have-coronavirus-four-being-tested>

⁹ Brian Honermann, *An "Epidemic Within an Outbreak:" The Mental Health Consequences of Infectious Disease Epidemics*, O'Neill Institute for National and Global Health Law (Feb. 26, 2015), accessed Mar. 19, 2020, <https://oneill.law.georgetown.edu/epidemic-within-outbreak-mental-health-consequences-infectious-disease-epidemics/>; Müller N, *Infectious Diseases and Mental Health*, Comorbidity of Mental and Physical Disorders; Shultz JM, *Mental Health Consequences of Infectious Disease Outbreaks*, accessed Mar. 19, 2020, <https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/flrtc/documents/Slides-MH-CONSEQUENCES-OF-ID-OUTBREAKSV2.pdf>.

disease outbreak such as COVID-19, may result in poor health outcomes and even death. The scientific evidence points to a bi-directional relationship between mental health conditions and infectious diseases. Not only are individuals with mental health conditions more at risk for communicable diseases, they are also harder to treat, once infected, due to the nature of their underlying mental health disorder. For individuals in these facilities, especially those with chronic mental health conditions, the experience of an epidemic and the lack of care while confined to small, crowded quarters can itself be traumatizing, compounding the trauma of incarceration.

26. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon many are sick—including high-risk groups such as those with chronic conditions—quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may be transferred.

27. 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.¹⁰ Subsequent CDC investigation of 995 inmates and 235 staff members across the two 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.¹¹ H1N1 is far less contagious than coronavirus. These scenarios occurred in the “best case” of influenza, a viral infection for which

¹⁰ *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention, Apr. 6, 2020, <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

¹¹ 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/>.

there was an effective and available vaccine and antiviral medications, unlike the coronavirus COVID-19, for which there is currently neither.

28. In recent years in immigration detention facilities, overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of other infectious diseases as well, including mumps and chickenpox.

29. Additionally, 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.

30. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of Coronavirus. Not surprisingly, Chinese prison officials report that over 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined. Recognizing that the release of those incarcerated is the only solution, US jails in at least a dozen states have begun releasing inmates. In Iran, over 80,000 prisoners were released as a means of preventing death in government prisons. Major human rights organizations such as Human Rights Watch, Physicians for Human Rights and Amnesty International have issued calls to release those detained in immigration facilities to prevent the spread of coronavirus.

31. In my professional opinion, it is inevitable that SARS-CoV-2, the virus that causes COVID-19, will infect prisons, jails, and/or other immigration detention centers in the United States. This is consistent with the prediction of other experts that all detention centers, prisons and jails should anticipate. Given the shortage of COVID-19 tests in the United States, it is likely that detention facilities are unable to conduct aggressive, widespread testing to identify all positive

coronavirus cases. The ability to identify cases is crucial in order to be able to determine whether there is a risk for coronavirus transmission in an institution.

IV. The Maryland Detention Facilities

32. Based on the description of the Maryland facilities contained in the Lopez Declaration, it is my professional opinion that the Maryland facilities are particularly susceptible to rapid spread of the virus and are not equipped to handle a coronavirus outbreak.

33. The living conditions described in the Lopez Declaration are not amenable to the necessary social distancing and hygiene measures that would be necessary to contain or minimize spread of the virus.

34. In particular, the fact that persons detained in those facilities share dorms, cells, living spaces, and bathroom space that is not disinfected between each use, and regularly interact with each other in narrow hallways and other areas where maintaining distance is not possible makes it all but inevitable that the virus would spread rapidly within the facility.

35. Because routine testing is not being undertaken at the facility, it is impossible to tell how many asymptomatic carriers of the disease may already be at the facility or to screen for new instances of the virus before an individual with COVID-19 becomes symptomatic. Since testing is not widely available, it is highly unlikely that the facility would even be able to keep up with the need to test individuals exhibiting symptoms for the virus. Rapid spread of the virus within the facility is therefore extremely likely.

36. The fact that medical units are shared spaces exacerbates this problem, as there appears to be no way to isolate individuals infected with the virus when this becomes necessary. The fact that there is only a small amount of space available in the medical unit makes it highly

unlikely that the facility could accommodate expanded need for services as a result of a coronavirus outbreak.

37. Moreover, the absence of 24-hour onsite medical facilities, the minimal and part-time nature of medical staffing, and that detainees appear to have had difficulties accessing routine medical care in the past renders it highly unlikely that the facility would be able to provide appropriate screening or treatment should that become necessary.

38. Based on the description of the facilities I have reviewed, it is my professional opinion that an outbreak is highly likely and that the consequences of rampant COVID-19 infection in the facility would be disastrous, especially for high-risk individuals like the plaintiffs in this case.

V. Specific Cases.

39. The two plaintiffs in this lawsuit present with personal health characteristics that put them at high risk for complications from COVID-19 should they be exposed to the virus in detention.

40. Mr. Coreas, who suffers from Diabetes is also at a higher risk for complications due to this chronic medical condition. According to the CDC and the American Diabetes Association, those with diabetes are at a higher risk for COVID-19 complications, but also to deadly conditions resulting from the viral infection itself overwhelming the body, such as DKA – or diabetic ketoacidosis.

41. Mr. Cedillo suffers from hypertension. Early research has shown that those with a diagnosis of hypertension have worse symptoms and are more likely to die from COVID-19.

VI. Conclusion and Recommendations

42. For the reasons above, it is my professional judgment that the plaintiffs, currently in ICE's immigration detention centers, are at a significantly higher risk of infection with Coronavirus as compared to the population in the community, and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac and kidney failure) and even death.

43. Given that the only viable public health strategy available in the United States currently is risk mitigation, reducing the size of the population in detention centers, jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless given the public health realities we now face in the United States.

44. Even with the best-laid plans to address the spread of Coronavirus in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my professional opinion, the only viable public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of an effective vaccine for prevention or effective treatment for the disease at this stage. My professional opinion is consistent with the view of the medical profession as a whole that there are no conditions of confinement in carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.

45. Immediate release is crucial for the above-mentioned individuals.

46. Releasing 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. It is my professional opinion that this step is both necessary and urgent. The window of opportunity is rapidly narrowing

for mitigation of COVID-19 in these facilities. It is a matter of days, not weeks. Once a case of Coronavirus is identified in a facility, it will likely be too late to prevent a widespread outbreak.

47. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.

48. Release of the most vulnerable people – such as the plaintiffs in this case -- also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

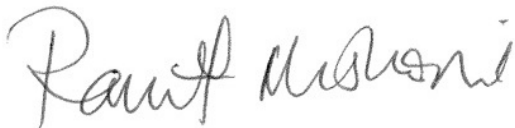
VII. Expert Disclosures

49. None.

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

Executed this 24th day of March, 2020 in Washington, D.C.

Ranit Mishori, M.D, MHS, FAAFP

A handwritten signature in cursive script, reading "Ranit Mishori". The ink is dark and the signature is fluid, with the first name "Ranit" and last name "Mishori" clearly distinguishable.

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities*, a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.¹
2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.
3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 132,000 people have been diagnosed with COVID-19 around the world and 4,947 have died.² In the United States, about 1,700 people have been diagnosed and 41 people have died thus far.³ These numbers are likely an underestimate, due to the lack of availability of testing.
4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.
5. People in the high-risk category for COVID-19, i.e., the elderly or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

¹ Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. *Journal of Correctional Health Care Online* First, published on May 12, 2010 as doi:10.1177/1078345810367593.

² See <https://experience.arcgis.com/experience/685d0ace521648f8a5beee1b9125cd>, accessed March 13, 2020.

³ See <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1>, accessed March 13, 2020.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.
7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.
8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. At least one nursing home in the Seattle area has had cases of COVID-19 and has been quarantined.
9. The Seattle metropolitan area, hit hard by COVID, is the epicenter of the largest national outbreak at this time. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the immigration detention facility in Tacoma, Washington. Immigration courts and the ICE field office in Seattle have already closed this month due to staff exposure to COVID-19.
10. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.
11. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the “social distancing” needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.
12. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.
13. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks

to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

14. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.
15. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from NWDC by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with the Pierce County or Washington State Department of Health.

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

Executed this 14th day in March, 2020 in New York City, New York.

A handwritten signature in blue ink, appearing to read "Robert B. Greifinger", written over a horizontal line.

Robert B. Greifinger, M.D.



Executive Order 2020-29 (COVID-19)

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

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.



The Emergency Management Act vests the governor with broad powers and duties to “cop[e] with dangers to this state or the people of this state presented by a disaster or emergency,” which the governor may implement through “executive orders, proclamations, and directives having the force and effect of law.” MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, “the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control.” MCL 10.31(1).



To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department's custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the "Department") must continue to implement risk reduction protocols to address COVID-19 ("risk reduction protocols"), which the Department has already developed and implemented at the facilities it operates and which include the following:
 - 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 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 for incarcerated persons to only appointments 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. 
- 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.
2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act (“CJOA”), 1982 PA 325, MCL 801.51 et seq., 

is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.

3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:
 - a. Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.
 - b. Anyone who is incarcerated for a traffic violation.
 - c. Anyone who is incarcerated for failure to appear or failure to pay.
 - d. Anyone with behavioral health problems who can safely be diverted for treatment.
4. Effective immediately, all transfers into the Department's custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department's risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.
5. Parole violators in the Department's custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.

6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department's custody if not for the suspension of transfers described in section 4 of this order.
7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:
 - a. Removing from the general population any juveniles who have COVID-19 symptoms.
 - b. Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.
 - c. Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.
 - d. To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.
8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended. 
9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.





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March 31, 2020

Sent via email

Re: Reducing Your Jail Population Pursuant to Executive Order 2020-29

Dear Sheriff:

The ACLU of Michigan (“ACLU”) and the State Appellate Defender Office (“SADO”) appreciate the efforts that many courts and law enforcement officials around the state have already taken to try to reduce jail populations in order to mitigate the probability of a disastrous COVID-19 outbreak in our jails and to reduce the impact when one inevitably occurs despite everyone’s best efforts. On March 29, 2020, Governor Whitmer signed Executive Order 2020-29, attached here for your convenience. The Order underscores 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 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.

We write to highlight the specific measures that sheriffs and courts can now take to further reduce jail populations under the JOA, as modified by EO 2020-29, while maintaining public safety. We note that Chief Justice Bridget McCormack and Sheriff Matt Saxton of the Michigan Sheriffs’ Association recently issued a press release urging courts and sheriffs to take similar measures, emphasizing that “[f]ollowing this advice WILL SAVE LIVES.” The ACLU and SADO agree.

It is important to note that all of the powers conferred by the JOA allow courts and sheriffs to act promptly and efficiently without conducting separate hearings in each individual case. And, as expressly authorized by EO 2020-29, you may immediately implement any or all of the JOA’s population reduction measures without regard to the capacity, procedural, and waiting-period requirements that strict compliance with the statute would otherwise entail. Accordingly, the following critical measures can now be taken immediately by judges and sheriffs working together—and as a matter of public health, *must* be taken without any delay—in order to reduce the risks of fatal COVID-19 outbreaks in our jails:

- Release of pre-trial detainees. The JOA permits the chief district judge, chief circuit judge, the sheriff (and in some jurisdictions a few additional judges) to vote to establish a “maximum value” for convertible cash bonds. The sheriff is then authorized to convert the bond of any person in jail because of inability to pay a bond up to the “maximum value” into a personal bond and to release that individual upon approval from the chief circuit judge. MCL 801.51a(1)(a), (2). Courts and sheriffs should immediately use this

power by establishing high “maximum values.” Then sheriffs should promptly provide lists of individuals who qualify for release because of their bond amount, and chief circuit judges should promptly and summarily approve such lists.

The JOA also provides ways to promptly and safely release most individuals whose cash bail exceeds the “maximum value.” The JOA allows chief judges to modify bond to facilitate the release of any pre-trial detainee, except for individuals accused of crimes against their romantic partner or children, who does not pose “a high risk to public safety.” MCL 801.56(2)(b), (3), (4)(b). Sheriffs should promptly provide lists of all individuals who are still in jail in a format that complies with MCL 801.56(2)(b). Chief judges should then make determinations about whether to modify bond as rapidly as possible and in recognition that an individual accused of a crime should not be presumed guilty and should not be presumed to be likely to re-offend in the absence of extraordinary facts suggesting a recurring pattern of violent activity.

- Release of prisoners who have served 85% of their sentence. The JOA permits sheriffs to release people who were convicted of most crimes immediately if they have already served 85% or more of their sentence, unless the chief circuit judge concludes that immediate release will present a threat to public safety. MCL 801.51a(1)(b). This option exists for all criminal convictions except “assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance.” Accordingly, sheriffs should immediately provide lists of eligible individuals who have served 85% of their sentence to chief circuit judges. Chief circuit judges should promptly order the release of all such people absent persuasive evidence that the individuals will be a danger to the public, evidence of which should be very rare given the offenses that are eligible for release.
- Reduction of sentences for other prisoners. The JOA provides three ways to reduce the sentences of people housed in county jails. First, section 56 states that sheriffs should provide a list of all individuals currently serving sentences in the jails to the chief circuit judges. MCL 800.56(2)(a). Chief circuit judges must then classify the list into two categories: individuals who present a “high risk to public safety” if released and those who do not. The chief judge can then set a minimum and maximum percentage amount by which sentences of the non-high risk individuals may be reduced, and the sheriff may immediately reduce the sentences of all such people by any amount within the range set by the chief judge. MCL 801.56(4)(a).

Second, sheriffs can *unilaterally* reduce the sentences of all people in a county jail by up to 30% without approval from a circuit judge. MCL 801.57.

Third, any sentencing judge “may suspend or reduce any validly imposed jail sentence imposed by that judge.” MCL 800.59b(1). Judges can delegate these powers to their chief judge. All judges should be encouraged to exercise this power (or delegate it to their chief judges) to reduce or suspend sentences of all people who do not pose an immediate high risk to public safety. In particular, judges should suspend sentences in

situations where the defendant has not yet begun to serve their sentence, so as to avoid introducing new individuals and risks into the carceral environment.

- Refuse to detain new people in the jails. The JOA authorizes sheriffs to defer admitting new detainees to the jail except for individuals convicted of certain, more serious, crimes, until the crisis has abated. Specifically, sheriffs may decline to admit new individuals to their jails unless such individuals have been convicted of “violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses.” MCL 801.58(1). Sheriffs are now able to exercise these powers to refuse to admit all new pre-trial detainees, people convicted of most offenses, as well as anyone charged with technical probation violations or failure to appear, unless the chief circuit judge affirmatively determines that detention is necessary because of a “threat to public safety.” Significantly, sheriffs can decline to admit new detainees under this section without first obtaining approval from the circuit court.
- Review and termination of agreements to house other detainees, especially ICE detainees. Section 55(f) of the JOA allows sheriffs to review agreements to house detainees from other governmental actors and authorizes termination of such arrangements. MCL 801.55(f). This allows sheriffs to revisit contracts to hold federal detainees, including ICE detainees. In our experience, most such contracts allow for immediate termination in the event of an “emergency.” Accordingly, sheriffs should consider immediately terminating such contracts and releasing ICE detainees as an efficient way to significantly reduce jail populations without imperiling public safety.¹

In addition, local jails should not hold people on detainers for Immigrations and Customs Enforcement (ICE), which are not judicially issued warrants, but are merely requests to hold individuals for ICE. See *Lopez-Lopez v. County of Allegan*, 321 F Supp 3d 794, 799 (WD Mich., 2018) (“[C]ooperation with ICE detainers is discretionary rather than mandatory”).

In addition to the specific powers enumerated above, the JOA includes several other measures that courts and jails have at their disposal to reduce jail populations. For example, MCL 801.55(a)–(q) sets forth a panoply of alternatives to incarceration that can be utilized. A full copy of the relevant provisions of the JOA are attached to this letter for your convenience.

EO 2020-29 also offers additional categories of people for special consideration of release. These include older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, people nearing their release date, people incarcerated for traffic violations or for failure to appear or failure to pay, and people with behavioral health problems who can safely be diverted for treatment.

¹ The standard Intergovernmental Service Agreement (IGSA) between county jails and ICE specifically provides that you can bring medically vulnerable individuals to ICE’s attention for release within 48 hours, and that limitations on releasing ICE detainees do not apply in “medical or emergency situations.”

Finally, EO 2020-29 complements the tools already in place to reduce jail populations. MCL 771.2(5) provides for modification of probation, where jail is a condition of the probation, and MCL 801.257 permits reductions of jail sentences by one quarter.

SADO and the ACLU of Michigan appreciate that sheriffs and courts have already been working around the clock in many jurisdictions to improve public safety. EO 2020-29 provides a powerful new tool to accelerate those efforts, and rapidly deploying these new powers is urgent to protect both people in jails, and jail staff and their loved ones, as well as the health of the public at large. Our organizations would be eager to speak with you about ways to facilitate the swift and safe release of people in jails pursuant to the Governor's order. Thank you for your consideration of these matters in a challenging time.

Sincerely,

Dan Korobkin, Legal Director
Phil Mayor, Senior Staff Attorney
ACLU of Michigan
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Jonathan Sacks, Director
State Appellate Defender Office
JSacks@sado.org

Cc: Chief Justice Bridget Mary McCormack (via email)
Matt Saxton, Executive Director, Michigan Sheriffs' Association



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GARLIN GILCHRIST II
LT. GOVERNOR

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

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to “cop[e] with dangers to this state or the people of this state presented by a disaster or emergency,” which the governor may implement through “executive orders, proclamations, and directives having the force and effect of law.” MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, “the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control.” MCL 10.31(1).

To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department’s custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the “Department”) must continue to implement risk reduction protocols to address COVID-19 (“risk reduction protocols”), which the Department has already developed and implemented at the facilities it operates and which include the following:
 - (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 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 for incarcerated persons to only appointments 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.

- (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.
2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act (“CJOA”), 1982 PA 325, MCL 801.51 et seq., is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.
3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:
 - (a) Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.
 - (b) Anyone who is incarcerated for a traffic violation.
 - (c) Anyone who is incarcerated for failure to appear or failure to pay.
 - (d) Anyone with behavioral health problems who can safely be diverted for treatment.
4. Effective immediately, all transfers into the Department’s custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department’s risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.
5. Parole violators in the Department’s custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.
6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department’s custody if not for the suspension of transfers described in section 4 of this order.

7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:
 - (a) Removing from the general population any juveniles who have COVID-19 symptoms.
 - (b) Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.
 - (c) Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.
 - (d) To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.
8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended.
9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.

Date: March 29, 2020

Time: 7:23 pm



GRETCHEN WHITMER
GOVERNOR

By the Governor:

SECRETARY OF STATE

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.51a County jail population exceeding 95% of jail's rated design capacity; actions by county sheriff; maximum value of outstanding bonds; duration; applicability of subsections (1) to (3).

Sec. 1a. (1) In a county other than a county described in subsection (4), the sheriff of that county shall take the following actions on the fifth consecutive day on which the general population of the county jail exceeds 95% of the jail's rated design capacity:

(a) The sheriff shall review the outstanding bonds for each prisoner. If the total of a prisoner's outstanding bonds does not exceed a maximum value determined as provided in subsection (2), the sheriff, subject to the approval of the chief circuit judge in that county, shall modify each outstanding bond for that prisoner to a personal recognizance bond in that same amount, issue to the prisoner a receipt similar to an interim bond receipt, and send a copy of the receipt to the court that set the bond.

(b) The following prisoners, except for any prisoner that the chief circuit judge in that county believes would present a threat to the public safety if released, shall be released immediately:

(i) Any sentenced prisoner who has served 85% or more of his or her sentence, unless he or she is serving a sentence for a violent or assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance.

(ii) Any prisoner detained in the county jail for a civil contempt adjudication for failure to pay child support who has no other charges pending against him or her.

(2) The maximum value of outstanding bonds, for purposes of subsection (1)(a), shall be determined by a majority vote of the following individuals, as applicable:

(a) In a single-county or multicounty judicial district, the chief circuit judge for the judicial circuit that includes that county, the chief district judge for that district, and the sheriff of the county.

(b) In a county containing 2 or more judicial districts, the chief circuit judge for the judicial circuit that includes that county, the chief probate judge for that county, the sheriff of the county, and 2 district judges chosen by the chief district judges sitting in that county.

(3) A determination made under subsection (2) remains in effect for 1 year after the date on which that determination was made.

(4) Subsections (1) to (3) do not apply to either of the following:

(a) A county for which a county jail management plan has been approved under section 9a.

(b) A county having a population greater than 650,000 as of the most recent federal decennial census that, on the effective date of this section, has implemented a written jail management plan in which the basis of the plan is jail bed allocation. The exception provided by this subsection applies only as long as that plan remains in effect.

History: Add. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.55 Reduction of prisoner population by sheriff, notified persons, and other judges; means.

Sec. 5. The sheriff, the persons notified pursuant to section 4, and other circuit, district, and municipal judges may attempt to reduce the prisoner population of the county jail through any available means which are already within the scope of their individual and collective legal authority, including, but not limited to, the following:

- (a) Accelerated review and rescheduling of court dates.
- (b) Judicial review of bail for possible bail reduction, release on recognizance, or conditional release of prisoners in the county jail.
- (c) Prosecutorial pre-trial diversion.
- (d) Judicial use of probation, fines, community service orders, restitution, and delayed sentencing as alternatives to commitment to jail.
- (e) Use of work-release, community programs, and other alternative housing arrangements by the sheriff, if the programs and alternative housing arrangements are authorized by law.
- (f) Review of agreements which allow other units of government to house their prisoners in the overcrowded county jail to determine whether the agreements may be terminated.
- (g) Entering into agreements which allow the sheriff for the county in which the overcrowded county jail is located to house prisoners in facilities operated by other units of government.
- (h) Refusal by the sheriff to house persons who are not required by law to be housed in the county jail.
- (i) Acceleration of the transfer of prisoners sentenced to the state prison system, and prisoners otherwise under the jurisdiction of the department of corrections, to the department of corrections.
- (j) Judicial acceleration of pending court proceedings for prisoners under the jurisdiction of the department of corrections who will be returned to the department of corrections regardless of the outcome of the pending proceedings.
- (k) Reduction of waiting time for prisoners awaiting examination by the center for forensic psychiatry.
- (l) Alternative booking, processing, and housing arrangements, including the use of appearance tickets instead of booking at the county jail and the use of weekend arraignment, for categories of cases considered appropriate by the persons notified pursuant to section 4.
- (m) Acceptance by the courts of credit cards for payments of bonds, fines, and court costs.
- (n) Use of community mental health and private mental health resources in the county as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.
- (o) Use of community and private substance abuse programs and other therapeutic programs as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.
- (p) Preparation of a long-range plan for addressing the county jail overcrowding problem, including recommendations to the county board of commissioners on construction of new jail facilities and funding for construction or other options designed to alleviate the overcrowding problem.
- (q) Review of sentencing procedures, including the elimination of delays in preparing presentence reports for prisoners awaiting sentence, and staggering the dates on which prisoners will start serving a jail sentence to minimize fluctuating demands on jail capacity.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.56 Requirement of further actions; failure of certain actions to reduce population to level prescribed in subsection (1); presenting prisoner information to chief circuit judge; applicability of subsection (2)(b) to certain prisoners; review; classification of prisoners; reduction of sentences; duration; report.

Sec. 6. (1) The further actions prescribed in subsections (2) to (5) and in sections 7 and 8 shall be required unless the actions taken pursuant to section 5 reduce the county's jail population to the higher of the following:

(a) 90% of rated design capacity or a percentage of rated design capacity less than 90% as set by a court prior to February 8, 1983.

(b) A prisoner population such that the jail has the following number of empty beds:

(i) For a jail with a rated design capacity of less than 500 beds, at least 10 empty beds.

(ii) For a jail with a rated design capacity of 500 beds or more, at least 25 empty beds.

(2) If the actions taken pursuant to section 5 do not reduce the county jail's population to the level prescribed in subsection (1) within 14 days after the declaration of the county jail overcrowding state of emergency, the sheriff shall present to the chief circuit judge for the county in which the jail is located the following information for each prisoner housed in the county jail on that date:

(a) For prisoners who are serving a sentence of imprisonment for conviction of 1 or more crimes:

(i) The name of each prisoner.

(ii) The offense for which the prisoner was convicted.

(iii) The length of sentence imposed for the prisoner.

(iv) The date on which the prisoner began serving his or her sentence.

(v) The date on which the prisoner will be released from the jail according to the terms of his or her sentence, including computations for good time.

(vi) The name of the judge who imposed the sentence.

(b) For prisoners housed in the county jail, other than a prisoner described in subsection (3), who are not serving a sentence of imprisonment for conviction of a crime:

(i) The name of the prisoner.

(ii) The offense for which the prisoner is being detained in the county jail.

(iii) The amount of the prisoner's bond.

(iv) The date on which the prisoner began his or her period of detention.

(v) The name of the judge who ordered the prisoner to be detained.

(3) Subsection (2)(b) does not apply to a prisoner who is detained in the county jail in connection with a crime or an allegation of a crime in which the victim was a spouse, a former spouse, an individual with whom he or she has had a child in common, an individual residing or having resided in the same household, or an individual with whom he or she has or has had a dating relationship as that term is defined in section 2950 of the revised judiciary act of 1961, 1961 PA 236, MCL 600.2950.

(4) After the chief circuit judge for the county in which the jail is located reviews the information presented by the sheriff pursuant to subsection (2), the chief circuit judge shall, for purposes of county jail population reduction, do both of the following:

(a) Classify prisoners who are serving sentences of imprisonment for conviction of crimes into 2 groups: those prisoners who, if released, would present a high risk to the public safety, and those who, if released, would not present a high risk to the public safety. The chief circuit judge shall also determine a minimum and a maximum percentage by which the sentences can be reduced. The sheriff shall reduce the sentences of all prisoners who, if released, would not present a high risk to the public safety by an equal percentage which is within the minimum and maximum percentages determined by the chief circuit judge.

(b) Review the list of prisoners housed in the county jail who are not serving a sentence for conviction of crimes and determine for each prisoner whether the release of that prisoner would or would not present a high risk to public safety. The chief circuit judge may do either or both of the following with regard to a prisoner whose release would not present a high risk to the public safety:

(i) Modify the bond of the prisoner, subject to any conditions reasonably necessary to ensure the appearance of the individual in court.

(ii) Release the prisoner subject to the condition that he or she be placed on electronic monitoring.

(5) The sentences of prisoners sentenced to and housed in the county jail after the fourteenth day of the county jail overcrowding state of emergency may continue to be reduced in the same manner as prescribed in subsections (2)(a) and (4)(a), but shall not be reduced after the county jail overcrowding state of emergency is

ended or after the sheriff orders a sentence reduction pursuant to section 7, whichever occurs first.

(6) The department of corrections, in cooperation with the Michigan sheriffs' association, shall annually report to the chairpersons of the senate and house standing committees responsible for legislation concerning corrections. The report shall evaluate the effect on the overcrowding state of emergency procedures under this section.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2008, Act 542, Imd. Eff. Jan. 13, 2009.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.57 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1); equal reduction of original sentences.

Sec. 7. If the actions taken pursuant to sections 5 and 6 do not reduce the county jail's population to the level prescribed in section 6(1) within 28 days of the declaration of the county jail overcrowding state of emergency, the original sentences, not including good time, of all prisoners sentenced to and housed in the county jail on that date shall be equally reduced by the sheriff by the least possible percentage reduction necessary, not to exceed 30%, to reduce the county jail's prisoner population to the level prescribed in section 6(1).

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

**801.58 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1);
deferring acceptance for incarceration of certain persons.**

Sec. 8. (1) Except as otherwise provided in this subsection and subsection (2), if the actions taken pursuant to sections 5, 6, and 7 do not reduce the county jail's population to the level prescribed in section 6(1) within 42 days of the declaration of the county jail overcrowding state of emergency, the sheriff shall defer acceptance for incarceration in the general population of the county jail persons sentenced to or otherwise committed to the county jail for incarceration until the county jail overcrowding state of emergency is ended pursuant to section 9, except that the sheriff shall not defer acceptance for incarceration all persons under sentence for or charged with violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses.

(2) The sheriff shall not defer acceptance of a prisoner for incarceration into the general population of the county jail if both of the following occur:

(a) The sheriff or the sentencing judge presents to the chief circuit judge for the county in which the county jail is located information alleging that deferring acceptance of the prisoner for incarceration would constitute a threat to public safety.

(b) The chief circuit judge, based upon the presence of a threat to public safety, approves of accepting the prisoner for incarceration.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.59b Suspension or reduction of jail sentence by sentencing judge; delegation of authority to chief judge; modification of bond.

Sec. 9b. (1) For purposes of this act, a sentencing judge may suspend or reduce any validly imposed jail sentence imposed by that judge. A sentencing judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the sentencing judge serves or his or her designee.

(2) For purposes of this act, a judge may modify bond set by the court for unsentenced prisoners. A judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the judge serves, or his or her designee.

History: Add. 2007, Act 139, Imd. Eff. Nov. 13, 2007.

Popular name: Jail Overcrowding Emergency Powers Act

DECLARATION OF DR. ADAM LAURING

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

I. Background and Qualification

1. My name is Adam Luring, M.D., Ph.D.
2. I am a board-certified medical doctor in Infectious Diseases
3. I have been a physician for more than 18 years, and I have worked in Infectious Diseases for 14 years.
4. My bio, attached as Exhibit A, includes a brief description of my education and relevant experience
5. My Curriculum Vitae, attached as Exhibit B, includes a full list of my honors, experience, and publications.
6. I am donating my time reviewing materials and preparing this Declaration. Any live testimony I provide will also be *pro bono*.

II. Heightened Risk of Epidemics in Jails and Prisons

7. As I will discuss below, the risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of multiple risks of transmission and exposure to individuals who become infected.
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, however, are closely connected to communities. Staff, visitors, contractors, and vendors pass between communities and these facilities and, if infected, these individuals can carry with them and transmit infectious diseases. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities, posing the same risk. 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 share dining halls, bathrooms, showers, telephones, and other common areas, the opportunities for transmission are greater. Where infectious diseases are transmitted from person to person by droplets, and no vaccine exists, the best initial strategy is to practice social distancing – maintaining a physical distance of at least six feet from any other person. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community.
10. 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, and significantly increases the likelihood of the spread of infection. For example, in mid-March, the jail at Rikers Island in New York City had not had a single confirmed COVID-19 case. By March 30, 167 inmates, 114 correction staff and 20 health workers at Rikers tested positive for COVID-19; two correction staff members have died and multiple inmates have been hospitalized.¹ As of April 8, Rikers had a rate of infection that is far higher than the infection rates of the most infected regions of the world. More than 700 people have tested positive for COVID-19, including more than 400 staff.² The Chief Medical Officer of Rikers has described a “public health disaster unfolding before our eyes.” In his view, following CDC guidelines has not been enough to stem the crisis: “infections in our jails are growing quickly despite these efforts.”³

¹ Jan Ransom, *We’re Left for Dead: Fears of Virus Catastrophe at Rikers Jail*, NY Times, Mar. 30, 2020.

² Asher Stockler, *More Than 700 People Have Tested Positive for Coronavirus on Rikers Island, Including Over 440 Staff*, Newsweek (April 8, 2020), <https://www.newsweek.com/rikers-island-covid-19-new-york-city-1496872>.

³ Ross MacDonald (@RossMacDonaldMD), Twitter (Mar. 30, 2020, 8:03 PM), <https://twitter.com/rossmacdonaldmd/status/1244822686280437765?s=12> (“I can assure you we were following the CDC guidelines before they were issued. We could

Like the explosive growth at Rikers, the Cook County Jail went from two confirmed COVID-19 cases on March 23 to more than 350 confirmed cases, 238 inmates and 115 staff members, two weeks later.⁴ As of April 13, the number of confirmed cases totaled 500, of which two-thirds are inmates.⁵

11. 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 jail or prison inmates, staff, and visitors.
12. Reduced prevention opportunities: During an infectious disease outbreak, people can curb their risk of infection by washing hands. Jails and prisons often do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers. When handwashing is unavailable, then the risk of infection and rate of infection spread is much greater. 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, telephones, 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.

have written them ourselves. . . [I]nfections in our jails are growing despite these efforts.”).

⁴ Timothy Williams and Danielle Ivory, *Chicago’s Jail Is Top U.S. Hot Spot as Virus Spreads Behind Bars*, NY Times (April 8, 2020), <https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html>.

⁵ Cheryl Corley, *The Covid-19 struggle in the Cook County Jail*, NPR (April 13, 2020), <https://www.npr.org/2020/04/13/833440047/the-covid-19-struggle-in-chicagos-cook-county-jail>

13. Additional 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 to everyone in the facility of a widespread outbreak.
14. 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.⁶ 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.
15. 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 containing the illness and caring for those who have become infected nearly impossible.
16. 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

⁶ 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).

access to testing equipment, laboratories, medications, and specialized equipment, such as ventilators.

17. 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 a pandemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves. To help ease the collective burden on Southeastern Michigan hospitals, the state is constructing make-shift field hospitals.⁷ The patient volume at Detroit's Sinai-Grace Hospital is so overwhelming that patients are lining the hallways, and patient care is suffering from staff, supplies, and equipment shortages.⁸ In some cases, patients have died waiting for medical attention.⁹

18. 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 may be limited. Locally, for example, two Wayne County Jail physicians, including the Jail's medical director, have died from COVID-19.¹⁰

⁷ *TCF Center makeshift hospital in Detroit ready to accept first patients*, WXYZ Detroit, Channel 7 (April 9, 2020) <https://www.wxyz.com/news/coronavirus/4-local-health-systems-will-help-staff-tcf-center-temporary-hospitals-first-patients-arriving-friday>

⁸ Paul P. Murphy, *Detroit hospital workers say people are dying in the ER hallways before help can arrive* (April 9, 2020), <https://www.cnn.com/2020/04/09/us/detroit-hospital-workers-sinai-grace-coronavirus/index.html>

⁹ *Id.*

¹⁰ Charlie LeDuff, *LeDuff: Covid Has Killed 2 Wayne County Jail Doctors, A Commander, And Still: Silence*, Deadline Detroit (April 13, 2020), https://www.deadlinedetroit.com/articles/24965/leduff_covid_has_killed_2_wayne_county_jail_doctors_a_commander_and_still_silence

19. 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.
20. 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.¹¹ 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.¹² Even facilities on “quarantine” continued to accept new cases” 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 Disease¹³

¹¹ *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>.

¹² 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-deathsare-few/>.

¹³ This whole section draws from Brooks 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>.

21. 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.¹⁴ 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. A recent study out of Singapore found 10% of new infections could be caused by asymptomatic patients.¹⁵ 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 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.
22. 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.¹⁶ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease,

¹⁴ 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>

¹⁵ Linda Givertash, *New Chinese data on asymptomatic coronavirus cases could help world response*, NBC News (April 9, 2020), <https://www.nbcnews.com/news/world/new-chinese-data-asymptomatic-coronavirus-cases-could-help-world-response-n1173896>.

¹⁶ *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/casesupdates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html.

and diabetes, and older age.¹⁷ 74% of cases requiring hospitalization are people over the age of 50.¹⁸ 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

23. The care of people who are infected with COVID-19 depends on how seriously they are ill.¹⁹ 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. As discussed earlier, Southeastern Michigan hospitals are already overwhelmed and beyond capacity to provide this type of intensive care. This will worsen as COVID-19 becomes more widespread in communities.

24. In order to reduce the burden on the local health systems, aggressive containment and COVID-19 prevention is of utmost importance. To this end, State of Michigan and the City of Detroit have mandated COVID-19 prevention strategies, such as “shelter in place” or “stay at home” orders, which have gone beyond containment and mitigation. Jails and prisons already have difficulty with containment because it requires

¹⁷ *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).

¹⁸ Center for Disease Control, Morbidity and Mortality Weekly Report – Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Cases (April 8, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm>

¹⁹ *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>.

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 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.

25. The time to act is now. Data from other settings demonstrates what happens when jails and prisons are unprepared for COVID-19. To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.²⁰ 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 Oakland County Jail

26. In preparing this report I have reviewed the declarations of Oakland County Jail Inmates Arsineau, Bates, Briggs, J. Cameron, M. Cameron, Kucharski, Lee, and Saunders.

27. Based on my expertise in virology, review of the relevant literature, and my review of the declarations referred to paragraph 25, it is my professional judgment that immediate action is necessary to stem the spread of COVID-19 in the Oakland County Jail and prevent an even worse outbreak, which will result in severe harm to detained individuals, jail staff, and the broader community. The Oakland County Jail is not only obviously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak assuming what is described in the declarations is true, but in some cases, according to declarants, it is intentionally exposing inmates to COVID-19 as retribution for raising concerns about safety. The reasons for this conclusion are detailed as follows.

²⁰ 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-preparecoronavirus-federal-prisons-providing-significant/story?id=69433690>.

28. According to the declarants, people confined in the jail sleep on bunks spaced one to three feet apart and in some cases are sleeping on the floor right next to cellmates. They further stated that inmates share showers, toilets, and sinks in small common areas, and some toilets are close to their beds. Declarants also state that much of the time, whether they are sitting, standing, walking, eating, or sleeping, they are within six feet of at least one other person. Notwithstanding their close proximity to one another, the declarants stated that there have been shortages in personal protective equipment, such as masks and gloves, for all people incarcerated and some working in the jail. Declarants further attested to the fact that staff inconsistently wears personal protective equipment when they interact with inmates. If these statements are true, the jail is not following basic CDC protection and prevention. And, given this layout and crowded environment in which individuals are held, largely without protection, it is impossible to provide an environment where social distancing can occur, and, in turn, impossible to prevent the risk or spread of infection.
29. According to the declarants, some inmates are not provided with regular access to soap, and, in some cases, have been without soap for more than one week. Declarants also state that they do not have access to any hand sanitizer or other personal sanitation supplies, even for purchase. The jail's failure to provide adequate hygiene supplies deprives individuals of the most important CDC-recommended measures to protect themselves from infection.
30. Declarants attested to the fact that individuals confined at the jail have limited access to disinfectant, if at all, or basic cleaning supplies with which to clean their shared cells, shared living quarters, common areas, or high-touch surfaces. High-touch surfaces, such as light switches, door and sink knobs, telephones, tables, etc., should be sanitized after each use. Failure to properly sanitize shared spaces, common areas, and high-touch surfaces that detained individuals heavily use, seriously increases the risk of the spread of COVID-19 and demonstrates the Jail's failure to take the most fundamental precautions for preventing the spread of the disease.
31. The declarations attest to significant neglect of inmates' medical needs and the ability to provide the care necessary to prevent serious illness or

death. The declarants stated that, although they were initially able to make requests for medical attention, those requests were ignored for days or dismissed. Presently, according to declarants, inmates are essentially unable to request medical attention because nurses and doctors are unavailable and jail guards tell the inmates that they cannot assist with those requests. This is true, according to declarants, even for inmates who are particularly vulnerable to risk of severe illness or death, as a result of underlying health conditions.

32. The Jail's failure to provide inmates with adequate medical care for their underlying chronic health conditions, as described by the declarants, results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected. According to their declarations, some Plaintiffs, and others held in the jail have serious medical vulnerabilities. A worsening outbreak in the jail would prove disastrous, and potentially fatal, for these medically vulnerable individuals. Based upon the declarations, it is apparent that the Jail is not providing adequate medical treatment to infected inmates. This is also worrisome because it will surely cause unnecessary risk of severe illness or death, and because patients from the Jail will further strain already-burdened Southeastern Michigan medical facilities who will have to absorb patients from the jail.

33. The declarants further attested to the fact that inmates who exhibit COVID-like symptoms, such as cough, shortness of breath, or a fever are not immediately tested or quarantined, if at all. Failure to adequately test for infection results in dramatic undercounting of persons infected, and, in turn, makes it impossible to protect against an outbreak.

34. The quarantine procedures described by declarants will not in any way mitigate or prevent the spread of infection. The declarants stated that the jail is "quarantining" presumably infected inmates in cells immediately adjacent to and within arms-reach of cells with inmates who are not presumed to be infected.

V. Conclusion and Recommendations

35. For the reasons above, it is my professional judgment that individuals placed in the Oakland 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 facility, 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.

36. Indeed, based on the circumstances described in the declarations, my expertise in virology, and based upon my knowledge and understanding of the ways in which the novel coronavirus is transmitted, 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..

37. For the medically vulnerable – 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 50²¹ – immediate release is the only option because the Jail's widespread neglect of medical needs and failure to both identify and quarantine infection, coupled with the inmates' limited access to lifesaving protections, if any, and inability to practice physical distancing creates a meaningfully higher risk of death.

38. From a public health perspective, it is my strong opinion that individuals who can **safely and appropriately** remain in the community must not be placed in the Oakland County Jail facilities at this time. I am also strongly of the opinion that individuals who are already in these facilities should be evaluated for release, and that a careful evaluation of procedural and housing guidance is created for those who remain in the facility during the “stay at home” mandate, and possibly until the epidemic is contained.

39. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in this facility is a matter of days, not weeks.

²¹ Center for Disease Control, Morbidity and Mortality Weekly Report – Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Cases (April 8, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm>

40. 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.

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

Executed on this 15th day of April 2020.

A handwritten signature in black ink, appearing to read 'A. Luring', is positioned above a horizontal line.

ADAM LAURING, M.D., Ph.D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Janet Malam,

Case No. 20-10829

Petitioner,

Judith E. Levy

v.

United States District Judge

Rebecca Adducci, *et al.*,

Mag. Judge Anthony P. Patti

Respondents.

_____ /

**AMENDED OPINION AND ORDER GRANTING IN PART
PETITIONER'S EMERGENCY APPLICATION FOR A
TEMPORARY RESTRAINING ORDER [2]¹**

This is an emergency petition challenging Janet Malam's mandatory detention pursuant to 8 U.S.C. § 1226(c) because of danger posed to her by the COVID-19 pandemic. Petitioner claims that her continued detention violates her Fifth Amendment rights by exposing her to substantial risk of illness and death. She requests a temporary restraining order (TRO) requiring that Respondents release her on her

¹ On April 6, 2020 the Court amended its April 5, 2020 Order to include additional terms of supervision.

own recognizance and refrain from re-detaining her for the pendency of her immigration proceedings.

For the foregoing reasons, the Court GRANTS IN PART this emergency application for relief.

BACKGROUND

Petitioner Janet Malam, born in the United Kingdom, is a lawful permanent resident. (ECF No. 1, PageID.3.) She was legally admitted to the United States in 1967 at the age of four and is now fifty-six years old. (*Id.*) Petitioner has been detained since March 4, 2020, in the Calhoun County Correctional Facility² in conjunction with removal proceedings at the Detroit Immigration Court. (*Id.*) She brings suit against the following Respondents: Rebecca Adducci, the Detroit District Director of United

² The parties each refer to the Calhoun County Correctional Facility with different terminology. See *Jail/Corrections Division*, Calhoun County, https://www.calhouncountymi.gov/departments/sheriffs_office/jail.php (last visited Apr. 5, 2020) (“Calhoun County Correctional Facility”); *Detention Facilities*, U.S. Immigrations and Customs Enforcement, <https://www.ice.gov/detention-facility/calhoun-county-correctional-center> (last visited Apr. 5, 2020) (“Calhoun County Correctional Center”); *Calhoun County Jail*, Google Maps, at https://www.google.com/maps/place/Calhoun+County+Jail/@42.3166565,-85.1757947,15z/data=!4m2!3m1!1s0x0:0x4f8faa7bcca370c4?sa=X&ved=2ahUKEwiRwvHM3NH0AhUQmHIEHWeUCI4Q_BIwCnoECA4QCA (last visited Apr. 5, 2020) (“Calhoun County Jail”). The Court will refer to Petitioner’s current place of detention as the Calhoun County Correctional Facility or CCCF.

States Immigration and Customs Enforcement (ICE); Matthew Albence, Deputy Director of ICE; Chad Wolf, Acting Secretary of the U.S. Department of Homeland Security; William Barr, Attorney General of the United States; ICE; and Heidi Washington, Director of the Michigan Department of Corrections (MDOC). (*Id.*)

Petitioner alleges that she suffers from a number of health conditions, including: multiple sclerosis; bipolar disorder; pain; anemia; essential primary hypertension; hypothyroidism; chronic obstructive pulmonary disease; fibromyalgia; mild cognitive impairment; carpal tunnel syndrome; severe major depressive disorder; opioid addiction; nicotine dependence; and polyneuropathy. (ECF No. 1, PageID.7.) According to Petitioner's extensive medical records, these diagnoses are current and accurate as of March 3, 2020. (ECF No. 1-4, PageID.31.)

Because Petitioner has committed two or more crimes involving moral turpitude, her detention is mandatory pursuant to 28 U.S.C. § 1226(c).³ On March 30, 2020, Petitioner filed a petition requesting

³ Petitioner does not specify the nature of these crimes in either her petition or this application. In their response to Petitioner's application for a temporary restraining order, Respondents note that Petitioner's charge of removal is based on a 2003 Michigan state conviction of Larceny from the Person, Mich. Comp. Laws § 750.737, a 2008 conviction of Larceny \$100 or Less in violation of a Taylor City,

emergency relief in either one of two forms: a writ of habeas corpus or an injunction “ordering Defendants to immediately release [Petitioner], with appropriate precautionary public health measures, on the grounds that her continued detention violates the Due Process Clause [of the Fifth and Fourteenth Amendments].” (*Id.* at PageID.17.) Petitioner simultaneously filed an Application for Temporary Restraining Order requesting that the Court order Petitioner’s release during the pendency of her immigration proceedings due to the substantial risk to her health posed by COVID-19 as a result of Petitioner’s continued detention in the enclosed group environment endemic to the Calhoun County Correctional Facility. (ECF No. 2.)

For the reasons stated below, the Court GRANTS Petitioner’s application for a temporary restraining order requiring her immediate release from detention for the duration of the COVID-19 State of Emergency in Michigan or until further Court order.

LAW AND ANALYSIS

Michigan ordinance, a 2009 conviction of Retail Fraud in violation of a City of Flat Rock, Michigan ordinance, a 2011 conviction of Attempted Simple Larceny in violation of a City of Tyler, Michigan ordinance, and a 2012 conviction of Retail Fraud 3rd Degree \$200 or less in violation of a City of Southgate, Michigan ordinance. (ECF No. 11-1, PageID.192.)

I. Jurisdiction

“Federal courts are not courts of general jurisdiction; they have only the power that is authorized by Article III of the Constitution and the statutes enacted by Congress.” *Hamama v. Adducci*, 912 F.3d 869, 874 (6th Cir. 2018) (citing *Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 541 (1986)). All courts have an “independent obligation to determine whether subject-matter jurisdiction exists, even in the absence of a challenge from any party.” *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 514 (2006) (citing *Ruhgras AG v. Marathon Oil Co.*, 526 U.S. 574, 583 (1999)). A court must determine whether it has jurisdiction before deciding a cause of action. *Steel Co. v. Citizens for a Better Env’t*, 523 U.S. 83, 95 (1998).

Petitioner pleads that “[t]he Court has subject matter jurisdiction over this case pursuant to Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause); the Due Process Clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution; 28 U.S.C. § 1331 (federal question); 28 U.S.C. §1651 (All Writs Act); and 28 U.S.C. § 2241 (habeas corpus).” (ECF No. 1, PageID.5.) The Court has jurisdiction to adjudicate Petitioner’s claims under 28 U.S.C. § 2241. Moreover, even if

Petitioner's claims could not be heard under 28 U.S.C. § 2241, 28 U.S.C. § 1331 provides an independent source of jurisdiction.

A. 28 U.S.C. § 2241 Jurisdiction

28 U.S.C. § 2241 provides a district court with jurisdiction over petitions for habeas corpus where a petitioner is “in custody in violation of the Constitution or laws or treaties of the United States.” 28 U.S.C. § 2241(c)(3). *See INS v. St. Cyr*, 533 U.S. 289, 298 (2001) (recognizing 28 U.S.C. § 2241 as a jurisdictional statute). For over 100 years, habeas corpus has been recognized as the vehicle through which noncitizens may challenge the fact of their detention. *See Chin Yow v. U.S.*, 208 U.S. 8, 13 (1908) (“Habeas corpus is the usual remedy for unlawful imprisonment.”) In 2001, the Supreme Court recognized the continued viability of the writ in cases involving the detention of noncitizens: “§ 2241 habeas corpus proceedings remain available as a forum for statutory and constitutional challenges to post-removal-period detention.” *Zadvydas v. Davis*, 533 U.S. 678, 688 (2001). In 2018, the Court ruled on the merits of a habeas petition challenging the validity of pre-removal detention. *Jennings v. Rodriguez*, 138 S. Ct. 830 (2018).

Respondents claim, citing *Luedtke v. Berkebile*, that the Court lacks jurisdiction to grant habeas relief because 28 U.S.C. § 2241 “is not the proper vehicle for a prisoner to challenge conditions of confinement.” *Luedtke v. Berkebile*, 704 F.3d 465, 466 (6th Cir. 2013). Though the Supreme Court has left as an open question “the reach of the writ with respect to claims of unlawful conditions of treatment or confinement,” *Boumedienne v. Bush*, 553 U.S. 732, 792 (2006), the Sixth Circuit, conversely, has held that “a § 2241 habeas petition is not the appropriate vehicle for challenging the conditions of . . . confinement.” *Velasco v. Lamanna*, 16 F. App’x 311, 314 (6th Cir. 2001). In 2018, the Sixth Circuit reiterated this holding, affirming a district court that dismissed a § 2241 petition raising an Eighth Amendment challenge to subpar prison conditions because such a claim must be brought in a civil-rights action such as one under *Bivens v. Six Unknown Named Agents of the Fed. Bureau of Narcotics*, 403 U.S. 388 (1971). *Solano-Moreta v. Fed. Bureau of Prisons*, No. 17-1019, 2018 WL 6982510 (6th Cir. Sep. 24, 2018); *but see Aamer v. Obama*, 742 F.3d 1023 (D.C. Cir. 2014) (“Habeas corpus tests not only the fact but also the form of detention.”) (internal citation

omitted); *Roba v. U.S.*, 604 F.2d 215 (2d Cir. 1979) (holding that § 2241 petition may be used to challenge conditions of confinement).

The Respondents argue that “there is no dispute that Petitioner brings a challenge to the conditions of her confinement.” (ECF No. 11, PageID.175.) On its face, the application appears to concern Petitioner’s conditions of confinement. Petitioner titles her claim for relief: “Freedom from Cruel Treatment and Conditions of Confinement.” (ECF No. 1, PageID.16.) But Petitioner may nonetheless bring her claim under 28 U.S.C. § 2241 because she seeks immediate release from confinement as a result of there being no conditions of confinement sufficient to prevent irreparable constitutional injury under the facts of her case.

Supreme Court and Sixth Circuit precedent support the conclusion that where a petitioner claims no set of conditions would be sufficient to protect her constitutional rights, her claim should be construed as challenging the fact, not conditions, of her confinement and is therefore cognizable in habeas. In *Nelson v. Campbell*, the Supreme Court held that a death-row inmate’s challenge to the method of his upcoming execution constituted a challenge to the conditions—not the fact or duration—of his execution, and therefore his claim fell outside the “core”

of habeas corpus. 541 U.S. 637, 644-45 (2004). However, the Court speculated that if the challenged method “were a statutorily mandated part of the lethal injection protocol, or if as a factual matter petitioner were unable or unwilling to concede acceptable alternatives,” there would be a “stronger argument that success on the merits, coupled with injunctive relief, would call into question the death sentence itself,” bringing the claim into the core of habeas corpus. *Id.* at 645. In *Adams v. Bradshaw*, the Sixth Circuit relied on *Nelson* to uphold habeas jurisdiction over a claim where a petitioner challenged the method of his execution but did not concede that any acceptable alternative existed. 644 F.3d 481, 483 (6th Cir. 2011) (“Adams has not conceded the existence of an acceptable alternative procedure. . . . Thus, Adams's lethal-injection claim, if successful, could render his death sentence effectively invalid.”) Here, Petitioner has not conceded the existence of acceptable alternative conditions of her confinement; her Fifth Amendment claim, if successful, would render her continued detention invalid.

In contrast to this case, claims which the Sixth Circuit has held noncognizable in habeas are those in which the petitioner seeks relief other than release from custody: *See Solano-Moreta*, 2018 WL 6982510,

at *1 (seeking transfer); *Luedtke v. Berkebile*, 704 F.3d 465, 465–66 (6th Cir. 2013) (challenge to lack of compensation and conditions of work performed in prison); *Hodges v. Bell*, 170 F. App’x 389, 390 (6th Cir. 2006) (seeking amelioration of conditions or transfer to mental health facility); *Sullivan v. United States*, 90 Fed. App’x 862, 862 (6th Cir. 2004) (seeking medical treatment in prison); *Lutz v. Hemingway*, 476 F.Supp. 2d 715, 718 (E.D. Mich. 2007) (seeking restoration of mail privileges in prison); *see also Martin v. Overton*, 391 F.3d 710, 712 (6th Cir. 2004) (seeking transfer). Indeed, in *Preiser v. Rodriguez*, the Supreme Court distinguished conditions of confinement claims from claims seeking immediate or speedier release. 411 U.S. 475, 500 (1973) (distinguishing habeas case seeking good-time credits from § 1983 conditions of confinement cases on the grounds that “none of the state prisoners in those cases was challenging the fact or duration of his physical confinement itself, and none was seeking immediate release or a speedier release from that confinement—the heart of habeas corpus.”)

Although Petitioner here titles her claim for relief “Freedom from Cruel Treatment and Conditions of Confinement,” her Petition is a challenge to the continued validity of her confinement, regardless of its

conditions. Petitioner argues that the only adequate relief is her release from confinement. As Petitioner explains,

[S]ocial distancing and hygiene measures [are] Janet’s only defense against COVID-19. Those protective measures are exceedingly difficult, if not impossible, in the environment of an immigration detention center, where Janet shares toilets, sinks, phones, and showers, eats in communal spaces, and is in close contact with the many other detainees and officers.

(ECF No. 1, PageID.16.) At the Court’s March 31, 2020 status conference for this case, counsel for Respondents conceded that social distancing between prisoners of at least six feet would be impossible at the Calhoun County Correctional Facility. This concession supports the conclusion of multiple doctors and public health experts: that “[t]he only viable public health strategy available is risk mitigation. . . . [T]he public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety” (ECF No. 6-1, PageID.87 (Declaration of Infectious Disease Epidemiologist Joseph Amon)); the only way to “prevent serious illness including death” in ICE facilities is to “release all people with risk factors.” (ECF No. 20-3, PageID.374 (Declaration of Dr. Robert B. Greifingert).)

In this case, Petitioner does not take issue with the steps taken at the Calhoun County Correctional Facility to mitigate the risk of detainees contracting COVID-19. Rather, she says that no matter what steps are taken, due to her underlying serious health conditions, there is no communal holding facility where she could be incarcerated during the Covid-19 pandemic that would be constitutional. Petitioner's claim must therefore be considered as a challenge to the continued validity of confinement itself. Accordingly, Petitioner's claim is properly brought under 28 U.S.C. § 2241, and the Court has jurisdiction.

B. 28 U.S.C. § 1331 Jurisdiction

Even if the Court were to lack jurisdiction under 28 U.S.C. § 2241, the Fifth Amendment provides Petitioner with an implied cause of action, and thus 28 U.S.C. § 1331 would offer an independent source of jurisdiction.

28 U.S.C. § 1331 provides that “[t]he district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.” Petitioner properly framed her pleading as a civil rights action “[i]n the alternative.” In addition to her request for a writ of habeas corpus, Petitioner requests “injunctive relief

ordering Defendants to immediately release Janet, with appropriate precautionary public health measures, on the grounds that her continued detention violates the Due Process Clause.” (ECF No. 1, PageID.17.) She titles her single claim for relief “Violation of Fifth Amendment Right to Substantive and Procedural Due Process (Unlawful Punishment; Freedom from Cruel Treatment and Conditions of Confinement.” (*Id.* at PageID.16.)

Should Petitioner’s habeas petition fail on jurisdictional grounds, the Fifth Amendment provides Petitioner with an implied cause of action, and accordingly 28 U.S.C. 1331 would vest the Court with jurisdiction. In *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, the Supreme Court first upheld the proposition that the Constitution itself provided an implied cause of action for claims against federal officials. 403 U.S. at 388. In 2017, the Supreme Court held that federal courts should not extend a *Bivens* remedy into new contexts if there exist any “special factors counseling hesitation.” *Ziglar v. Abassi*, 137 S.Ct. 1843, 1857 (2017). However, there is no corresponding limitation on the Constitution as a cause of action to seek injunctive or other equitable relief. *See Ziglar*, 137 S. Ct. at 1862 (declining to extend

Bivens to conditions of confinement claim, but noting that “Respondents . . . challenge large-scale policy decisions concerning the conditions of confinement imposed on hundreds of prisoners. To address those kinds of decisions, detainees may seek injunctive relief.”). Instead, there is a “presumed availability of federal equitable relief against threatened invasions of constitutional interests.” *Hubbard v. E.P.A.*, 809 F.2d 1, 11 (D.C. Cir. 1986) (citing *Bivens*, 403 U.S. at 404 (Harlan, J., concurring)). Indeed, “the power of the federal courts to grant equitable relief for constitutional violations has long been established.” *Mitchum v. Hurt*, 73 F.3d 30, 35 (3d Cir. 1995). Here, Petitioner seeks only injunctive and declaratory relief. Accordingly, she may bring her claim directly under the Fifth Amendment, and the Court has jurisdiction to hear the claim under 28 U.S.C. § 1331.

At oral argument, counsel for Respondent raised the question of whether the United States may be entitled to sovereign immunity if Petitioner brought this case under the Fifth Amendment. Sovereign immunity does not apply in this instance, and even if it did, it has been statutorily waived. Federal courts may exercise the traditional powers of equity in cases within their jurisdiction to enjoin violations of

constitutional rights by government officials. In *Ex Parte Young*, the Supreme Court first articulated the principle that state government officials may be sued for acting unconstitutionally, even if an ensuing injunction would bind the state. 209 U.S. at 123. In *Philadelphia Co. v. Stimson*, the Supreme Court recognized the applicability of that principle to suits against federal officials. 223 U.S. 605, 620 (1912) (“in case of an injury threatened by his illegal action, the officer cannot claim immunity from injunction process”). More recently, the Supreme Court affirmed this principle in *Dalton v. Specter*: “sovereign immunity would not shield an executive officer from suit if the officer acted either ‘unconstitutionally or beyond his statutory powers.’” 511 U.S. 462, 472 (1994) (citing *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 691 n.11 (1949)). In *Malone v. Bowdoin*, the Court called this principle the “constitutional exception to the doctrine of sovereign immunity.” 369 U.S. 643, 647 (1962). Petitioner here raises a constitutional challenge to her detention as the result of actions taken by Respondent Adducci, a federal officer. Sovereign immunity does not apply.

Even absent this constitutional exception, the Administrative Procedure Act (APA) provides a statutory waiver to any defense of sovereign immunity. 5 U.S.C. § 702 provides that:

An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party.

In 2013, the Sixth Circuit recognized that this waiver extends beyond suits brought under the APA:

[W]e now join all of our sister circuits who have done so in holding that § 702's waiver of sovereign immunity extends to all non-monetary claims against federal agencies and their officers sued in their official capacity, regardless of whether plaintiff seeks review of “agency action” or “final agency action” as set forth in § 704.

Muniz-Muniz v. U.S. Border Patrol, 741 F.3d 668, 673 (6th Cir. 2013); *see also Chamber of Commerce v. Reich*, 74 F.3d 1322, 1328 (D.C. Cir. 1996) (“The APA’s waiver of sovereign immunity applies to any suit whether under the APA or not.”). ICE is a federal agency, of which Respondent Adducci is an officer or employee thereof. Petitioner challenges

Respondent's actions made in her official capacity. Accordingly, the APA provides a statutory waiver of sovereign immunity.

C. Petitioner's Status as a Noncitizen

Petitioner's status as a noncitizen who is undergoing removal proceedings does not affect the Court's jurisdiction to hear this case. Although several statutes limit a district court's authority to hear cases in the immigration context, none apply here, as set forth below.

28 U.S.C. § 1252(b)(9) provides that judicial review of:

all questions of law and fact, including interpretation and application of constitutional and statutory provisions, arising from any action taken or proceeding brought to remove an alien from the United States under this subchapter [including §§ 1225 and 1226] shall be available only in judicial review of a final order under this section.

28 U.S.C. § 1252(b)(9). Petitioner does not have a final order of removal. In *Jennings v. Rodriguez*, the Supreme Court held that 1252(b)(9) did not strip jurisdiction from courts to hear challenges to detention pending removal because detention was not an action taken to remove a noncitizen from the United States. 138 S. Ct. 830, 841 (2018). Petitioner challenges her continued detention; accordingly, 28 U.S.C. § 1252(b)(9) does not strip this Court of jurisdiction.

8 U.S.C. § 1226(e) bars federal court review of any discretionary decision made by the Attorney General regarding detention, release, bond, or parole in an immigration case. However, in *Demore v. Kim*, 123 S. Ct. 1708, 1713–14 (2003), the Supreme Court held that § 1226(e) did not prevent noncitizens from raising constitutional challenges to mandatory detention under § 1226(c). Petitioner here raises a Fifth Amendment challenge to her continued mandatory detention under § 1226(c); thus, § 1226(e) does not prevent this Court from exercising jurisdiction.

Finally, 8 U.S.C. § 1252(f), titled “Limit on Injunctive Relief,” provides that:

[N]o court (other than the Supreme Court) shall have jurisdiction or authority to enjoin or restrain the operation of the provisions of part IV of this subchapter, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, other than with respect to the application of such provisions to an individual alien against whom proceedings under such part have been initiated.

8 U.S.C. § 1252(f)(1). But as the Supreme Court recognized in *Reno v. Amer.-Arab Anti-Discrim. Comm.*, “this ban does not extend to individual cases.” 525 U.S. 471, 481–82 (1999). Petitioner seeks individual relief.

Therefore, 8 U.S.C. § 1252(f) does not affect this Court’s jurisdiction to enter injunctive or declaratory relief.

II. Proper Habeas Respondent

Petitioner names as Respondents: Rebecca Adducci, the Detroit District Director of ICE; Matthew Albence, Deputy Director; Chad Wolf, Acting Secretary of the U.S. Department of Homeland Security; William Parr, Attorney General of the United States; U.S. Immigration and Customs Enforcement; and Heidi Washington, Director of the Michigan Department of Corrections. Only Respondent Rebecca Adducci is properly named with respect to the petition for a writ of habeas corpus.

“Historically, the question of who is ‘the custodian,’ and therefore the appropriate respondent in a habeas suit, depends primarily on who has power over the petitioner and . . . on the convenience of the parties and the court.” *Roman v. Ashcroft*, 340 F.3d 314, 319 (6th Cir. 2003) (citing *Henderson v. INS*, 157 F.3d 106, 122 (2d Cir. 1998)). In *Roman*, the Sixth Circuit held that for habeas petitions in immigration contexts, “the INS District Director for the district where a detention facility is located ‘has power over’ alien habeas corpus petitioners.” *Id.* at 320. The court, in finding that the Attorney General was not a proper respondent

for a noncitizen’s habeas claim and that a habeas claim could properly have only one respondent, reiterated 28 U.S.C. § 2243’s requirement that a writ of habeas corpus “shall be directed to *the* person having custody of the person detained.” *Id.* at 321. Michigan only has one ICE District, located in Detroit. *See Enforcement and Removal Operations Field Offices*, <https://www.ice.gov/contact/ero>. Accordingly, Rebecca Adducci, the Detroit District Director, is the proper Respondent for Petitioner’s request for a writ of habeas corpus.

III. Petitioner’s Application for a Temporary Restraining Order

Petitioner, along with her complaint, filed an emergency application for a temporary restraining order. (ECF No. 3.) In determining whether to grant such an order, courts evaluate four factors: 1) whether the movant has a strong likelihood of success on the merits; 2) whether the movant would suffer irreparable injury absent an injunction; 3) whether granting the injunction would cause substantial harm to others; and 4) whether the public interest would be served by granting the injunction. *Northeast Ohio Coal. for Homeless and Serv. Emps. Intern. Union, Local 1199 v. Blackwell*, 467 F.3d 999, 1009 (6th Cir. 2006). These four factors “are not prerequisites that must be met,

but are interrelated considerations that must be balanced together. For example, the probability of success that must be demonstrated is inversely proportional to the amount of irreparable injury the movants will suffer absent the stay.” *Id.* (internal quotations omitted). “[P]reliminary injunctions are extraordinary and drastic remedies [] never awarded as of right.” *Am. Civil Liberties Union Fund of Michigan v. Livingston Cty.*, 796 F.3d 636, 642 (6th Cir. 2015). Nonetheless, each of the four factors weighs in Petitioner’s favor, and the Court grants Petitioner’s motion for a temporary restraining order.

A. Irreparable Harm

Petitioner is likely to experience irreparable injury absent an injunction, both in the form of loss of health or life, and in the form of an invasion of her constitutional rights.

1. Loss of Health or Life from COVID-19

The ongoing COVID-19 pandemic creates a high risk that absent an injunction by this Court, Petitioner will suffer irreparable harm in the form of loss of health or life as a result of contracting the COVID-19 virus.

On March 22, 2020, the Governor of Michigan issued the following statement: “The novel coronavirus (COVID-19) is a respiratory disease

that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.” Executive Order, No. 2020-20 (Mar. 22, 2020).

Since March 4, 2020, the date of Petitioner’s detention at the Calhoun County Correctional Facility, the exceptionally dangerous nature of the COVID-19 pandemic has become apparent. On March 10, 2020, the Governor of Michigan announced the state’s first two cases of COVID-19 and simultaneously declared a State of Emergency. Executive Order, No. 2020-4 (Mar. 10, 2020). The number of new cases then began to grow exponentially. As of April 5, 2020, there are now 15,718 confirmed cases of COVID-19 and 617 known related deaths, with 238 confirmed cases within the Michigan Department of Corrections system specifically.

See *Coronavirus*, Michigan.gov, <https://www.michigan.gov/coronavirus/0,9753,7-406-98163-520743--,00.html>. COVID-19 has a high risk of transmission, and the number and

rate of confirmed cases indicate broad community spread.⁴ Executive Order, No. 2020-20 (Mar. 22, 2020). Nationally, ICE detention facilities across our country are experiencing the same thing. As of April 4, 2020, ICE has confirmed at least 13 cases of COVID-19 among immigration detainees and 7 cases among detention facility employees and personnel. *ICE Guidance on COVID-19*, U.S. Immigration and Customs Enforcement, <https://www.ice.gov/coronavirus> (updated Apr. 4, 2020 at 8:00pm).

On March 23, 2020, the Centers for Disease Control and Prevention (CDC) acknowledged that correctional and detention facilities “present[] unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors.” *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control (Mar. 23, 2020),

⁴ Indeed, since the time of Respondent’s brief, the numbers have continued to grow. Respondent reported that, as of April 3, 2020, Calhoun County alone had 25 cases. (ECF No. 11, PageID.169) By the time the Court held oral argument later that day, that number had grown to 31, with 1 reported death. On April 5, the date of this Order, the number of confirmed cases is now 42, with 1 reported death. *Coronavirus*, https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html.

<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>. [Hereinafter “CDC Guidance 3/23/2020”]. Specifically, the CDC noted that many detention conditions create a heightened risk of danger to detainees. These include: low capacity for patient volume, insufficient quarantine space, insufficient on-site medical staff, highly congregational environments, inability of most patients to leave the facility, and limited ability of incarcerated/detained persons to exercise effective disease prevention measures (e.g., social distancing and frequent handwashing). *Id.*

Though the CDC has recommended public health guidance for detention facilities, and though the Calhoun County Correctional Facility has indeed implemented measures designed to prevent spread of the disease, these measures are inadequate to sufficiently decrease the substantial likelihood that Petitioner will contract COVID-19. As prison officials are beginning to recognize around the country, even the most stringent precautionary measures—short of limiting the detained population itself—simply cannot protect detainees from the extremely high risk of contracting this unique and deadly disease. For example, on April 1, 2020, the Rikers Island jail complex’s chief physician

acknowledged that “infections are soaring” despite the facility’s “following Centers for Disease Control and Prevention guidelines and having moved mountains to protect our patients.” Miranda Bryant, *Coronavirus Spread at Rikers is a ‘Public Health Disaster’, Says Jail’s Top Doctor*, The Guardian (Apr. 1, 2020), <https://www.theguardian.com/us-news/2020/apr/01/rikers-island-jail-coronavirus-public-health-disaster>. In the immigration context specifically, despite Respondents’ argument that the federal government has effectively incorporated appropriate and effective precautions, medical experts at the Department of Homeland Security have warned that detention confinement creates a “tinderbox scenario” where rapid outbreak is extremely likely, and extremely likely to lead to deadly results as resources dwindle on an exponential level. Catherine E. Shoichet, *Doctors Warn of ‘Tinderbox Scenario’ if Coronavirus Spreads in ICE Detention*, CNN (Mar. 20, 2020), <https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html>.

Petitioner is 56 years old and suffers from the following conditions, almost all of which place her at an increased risk of a dire outcome from

contracting the COVID-19 virus: multiple sclerosis, bipolar disorder, anemia, essential primary hypertension, hypothyroidism, chronic obstructive pulmonary disease, fibromyalgia, severe major depressive disorder, opioid addition, and polyneuropathy. (ECF No. 1-4, PageID.31.)

See Centers for Disease Control, *Groups at Higher Risk for Severe Illness*, (Apr. 2, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html> (noting that “people of all ages with underlying medical conditions are at higher risk for severe illness, particularly if the underlying medical conditions are not well controlled”).

Additionally, Respondents have confined Petitioner in an environment where she “shares toilets, sinks, phones, and showers, eats in communal spaces, and is in close contact with the many other detainees and officers.” (ECF No. 1, PageID.16.) Petitioner’s involuntary interaction with purportedly asymptomatic guards who rotate shifts is also a significant exposure factor. *How COVID-19 Spreads*, CDC (April 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how->

covidspreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html.⁵

These are many of the conditions that the CDC has identified as being particularly likely to increase COVID-19 transmissions in detention facilities. CDC Guidance 3/23/2020. For these reasons, Petitioner's confinement at the Calhoun County Correctional Facility renders her substantially likely to contract COVID-19, and Petitioner's severe health conditions render her substantially likely to suffer irreparable harm or death as a result.

Respondents focus on one particular issue: whether Petitioner is more likely to contract COVID-19 if released than if she remains confined in their jail. Respondents acknowledge that "there is a health risk posed by COVID-19 and that Petitioner is in the category of people identified to be at higher risk for serious health consequences if she contracts COVID-

⁵ On April 3, 2020, after Petitioner filed her emergency application for a temporary restraining order, the CDC updated its guidance in light of new evidence of asymptomatic transmission of COVID-19 to recommend that all individuals wear cloth face coverings "in public settings where other social distancing measures are difficult to maintain." *Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission*, CDC (Apr. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html>.

19.” (ECF No. 11, PageID.178.) Respondents also acknowledge that Petitioner “does not have to wait until she has COVID-19 to claim that the precautions taken to reduce exposure were insufficient.” (*Id.* at PageID.179.) Indeed, the crux of Respondents’ argument is not that COVID-19 does not pose a deadly threat to Petitioner if contracted. Rather, Respondents’ argument relies on the proposition that Petitioner does not have a substantial risk for *exposure* at the Calhoun County Correctional Facility, and her risk of exposure in the community may be greater. (*Id.* at PageID.178.)

To this end, Respondents posit the following: Petitioner has not established that she has either been exposed to COVID-19, or that her exposure is “imminent,” because there are currently no cases in the facility in which she is detained “and only 25 cases in the surrounding county.”⁶ (ECF No. 11, PageID.179.) Additionally, Respondents argue that their facility has implemented “numerous precautions to reduce the risk of exposure and spread of COVID-19,”⁷ and that even if Petitioner is

⁶ Hours later, due to the exponential nature of COVID-19’s spread, this statistic was already out of date. *See supra* fn.2.

⁷ Specifically, Respondents note that the ICE and CCCF precautions are as follows: tracking the disease, screening incoming detainees, isolating and testing

at a “generalized risk” of contracting COVID-19, that does not mean that she is at a “substantial risk” for purposes of her constitutional claim. (*Id.* at PageID.179-180, citing *Wooler v. Hickman Cty.*, 377 Fed. Appx. 502, 505 (6th Cir. 2010)).

Respondents’ arguments fail to address the stark reality of this particular global public health crisis. In the face of a deadly pandemic with no vaccine, no cure, limited testing capacity, and the ability to spread quickly through asymptomatic human vectors, a “generalized risk” *is* a “substantial risk” of catching the COVID-19 virus for any group of human beings in highly confined conditions, such as Petitioner within the CCCF facility. In acknowledgment of this simple truth, both the United States Attorney General and the Governor of Michigan have issued independent directives to consider early release for detainees who do not pose a public safety risk, as minimizing crowded populations is the only known way to mitigate spread of this pandemic. *Prioritization of*

symptomatic detainees, quarantining detainees who test positive, screening incoming staff, suspending in-person social visitation and limiting professional visitation to non-contact, increasing sanitation, educating all staff and detainees, providing detainees with toilet paper, personal soap, and disinfectants, and increasing hand-washing stations. (ECF No. 11, PageID.172.)

Home Confinement as Appropriate in Response to COVID-19 Pandemic, Att’y Gen. (Mar. 26, 2020); Executive Order, No. 2020-29 (COVID-19) (Mar. 26, 2020). Moreover, Petitioner’s risk of contracting COVID-19 outside of Respondents’ custody has no bearing on whether they have exposed her to the likelihood of irreparable harm. Though the Court commends Respondents for the steps they have taken to prevent spread of the disease, as prisons and courts around the country are beginning to recognize, such measures are insufficient to stem deadly prison outbreaks. *See, e.g., New York City Board of Correction Calls for City to Begin Releasing People From Jail as Part of Public Health Response to COVID-19*, N.Y.C. Bd. of Corr. (Mar. 17, 2020), <https://www1.nyc.gov/assets/boc/downloads/pdf/News/2020.03.17%20-%20Board%20of%20Correction%20Statement%20re%20Release.pdf> (arguing that, despite the “heroic work” of Department of Correction and Correctional Health Services staff “to prevent the transmission of COVID-19 in the jails and maintain safe and humane operations, the City must drastically reduce the number of people in jail right now and limit new admissions to exceptional circumstances.”). Even the Calhoun County Correctional Facility’s additional measure of screening incoming

shift workers for high temperatures is insufficient to stem the spread of disease, as COVID-19 spreads asymptotically. *How COVID-19 Spreads*, CDC (Apr. 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covidspreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html.

Accordingly, the Court concludes that Petitioner’s continued confinement at the Calhoun County Correctional Facility exposes her to a substantial risk of contracting COVID-19, which due to her specific underlying health conditions exposes her to a substantial risk of irreparable harm to her health or life.

2. Violation of Constitutional Rights

Petitioner’s Fifth Amendment claim triggers a finding that Petitioner will suffer irreparable harm absent an injunction. Petitioner alleges that in “subjecting Janet to detention conditions that amount to punishment and that fail to ensure her safety and health,” Respondent is “subjecting [her] to a substantial risk of serious harm, in violation of [her] rights under the Due Process Clause.” (ECF No. 1, PageID.17.) The alleged violation of a constitutional right is sufficient for a court to find

irreparable harm. *See Overstreet v. Lexington-Fayette Urban Cty. Gov.*, 305 F.3d 566, 578 (6th Cir. 2002) (citing *Connection Distrib. Co. v. Reno*, 154 F.3d 281, 288 (6th Cir. 1998); *Covino v. Patrissi*, 967 F.2d 73, 77; *McDonell v. Hunter*, 746 F.2d 785, 787 (8th Cir. 1984) ; *see also Rhinehart v. Scutt*, 408 F. App'x 510, 514 (6th Cir. 2018) (suggesting that allegation of “continuing violation of . . . Eighth Amendment rights” would trigger a finding of irreparable harm). Below, the Court finds Petitioner is likely to succeed on the merits of this Fifth Amendment claim. Accordingly, “no further showing of irreparable injury is necessary.” *Mitchell v. Cuomo*, 748 F.2d 804, 806 (2d Cir. 1984) (“When an alleged deprivation of a constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary.”).

B. Likelihood of Success on the Merits

Petitioner is likely to succeed on the merits of her claim that her continued confinement during the COVID-19 pandemic violates her Fifth Amendment rights.

The Due Process Clause of the Fifth Amendment to the United States Constitution forbids the government from depriving a person of life, liberty, or property without due process of law. U.S. Const. amend.

V. The protection applies to “all ‘persons’ within the United States, including [noncitizens], whether their presence here is lawful, unlawful, temporary, or permanent.” *Zadvydas v. Davis*, 533 U.S. 678, 693 (2001). As it pertains to Petitioner, the Due Process Clause prohibits the government from imposing torture or cruel and unusual confinement conditions on non-convicted detainees. *See Bell v. Wolfish*, 441 U.S. 520, 535 (1979) (“[U]nder the Due Process Clause, a detainee may not be punished prior to an adjudication of guilt.”). This type of Fifth Amendment claim is analyzed “under the same rubric as Eighth Amendment claims brought by prisoners.” *Villegas v. Metropolitan Government of Nashville*, 709 F.3d 563, 568 (6th Cir. 2013).

Eighth Amendment claims require a showing of deliberate indifference, *see Farmer v. Brennan*, 511 U.S. 825, 835 (1994), which has both an objective and a subjective component. *Villegas v. Metro. Gov’t of Nashville*, 709 F.3d 563, 568 (6th Cir. 2013) (citing *Harrison v. Ash*, 539 F.3d 510, 518 (6th Cir. 2008)).

1. Objective Component

The objective component is satisfied by showing that, “absent reasonable precautions, an inmate is exposed to a substantial risk of

serious harm.” *Richko v. Wayne Cty.*, 819 F.3d 907, 915 (6th Cir. 2016) (citing *Amick v. Ohio Dep't of Rehab. & Corr.*, 521 Fed.Appx. 354, 361 (6th Cir.2013)). Respondents argue that the precautions they have taken at the Calhoun County Correctional Facility combined with the lack of a confirmed outbreak of COVID-19 at the facility show that Petitioner is unable to demonstrate she is at substantial risk of serious harm. (ECF No. 11, PageID.180.) Instead, Respondents argue that Petitioner merely has a “generalized risk” of contracting COVID-19, which is insufficient to prevail on a Fifth Amendment constitutional claim. (*Id.*) But as noted above, in Petitioner’s case, a generalized risk is a substantial risk.

As the Supreme Court explained in *Helling v. McKinney*, “[w]e have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may 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.” 509 U.S. 25, 33 (1993). “That the Eighth Amendment protects against future harm to inmates is not a novel proposition.” *Id.* “It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening

condition in their prison on the ground that nothing yet had happened to them.” *Id.*

Respondents attempt to distinguish this case from *Helling* on the grounds that the Petitioner in *Helling* alleged a sufficiently imminent danger from “actual exposure to high levels of cigarette smoke because his former cellmate was a five-pack a day smoker.” (ECF No. 11, PageID.179 (citing *Helling*, 509 U.S. at 29).) Respondents argue that “Petitioner has not established that she either has been exposed to COVID-19, or that her exposure is “imminent.”” (*Id.*) But as the above analysis regarding the risk of irreparable injury to Petitioner demonstrates, the Respondents grievously underestimate the seriousness of the risk to Petitioner, in spite of precautionary measures and despite the lack of confirmed CCCF outbreak to date. The ever-growing number of COVID-19 outbreaks in prisons and detention facilities,⁸ despite a range of precautionary measures, demonstrates that

⁸ See, e.g., Ted Rod Roelofs, *Coronavirus Cases Surge in Michigan’s Crowded Prisons*, Bridge (Mar. 27, 2020), <https://www.bridgemi.com/michigan-government/coronavirus-cases-surge-michigans-crowded-prisons>; *Oregon Inmate in Salem Tests Positive for COVID-19, the First in the State Prison System*, SalemReporter (Apr. 3, 2020), <https://www.salemreporter.com/posts/2168/oregon-inmate-in-salem-tests-positive-for-covid-19-the-first-in-the-state-prison-system> (noting outbreak despite precautionary measures); Ames Alexander and Jessica

the risk of a COVID-19 outbreak in Respondent's facility is significant. Nor, given the percentage of asymptomatic COVID-19 cases and the virus' incubation period of up to fourteen days, can Respondents reasonably assert, as they do, that there are no COVID-19 cases in CCCF; they can only allege that there are no confirmed cases. By the time a case is confirmed, it will almost certainly be too late to protect Petitioner's constitutional rights. Petitioner, so long as she remains detained, is therefore exposed to a substantial risk of serious harm.

2. Subjective Component

The subjective component is demonstrated by showing that “(1) the official being sued subjectively perceived facts from which to infer a substantial risk to the prisoner, (2) the official did in fact draw the inference, and (3) the official then disregarded that risk.” 819 F.3d at 915–16 (citing *Rouster v. Cty. of Saginaw*, 749 F.3d 437, 446 (6th Cir. 2014)). “Because government officials do not readily admit the subjective

Banov, *In NC Prisons, Five Employees and Four Inmates Have Now Tested Positive for COVID-19*, Charlotte Observer (Apr. 1, 2020), <https://www.charlotteobserver.com/news/coronavirus/article241675886.html>; Alexandra Kelley, *Louisiana Prison Records Third Inmate Death as a Result of the Coronavirus*, The Hill (Apr. 1, 2020), <https://thehill.com/changing-america/well-being/prevention-cures/490839-louisiana-prison-records-third-inmate-death-as-a>.

component of this test, it may be demonstrated in the usual ways, including inference from circumstantial evidence. . . .” *Richko*, 819 F.3d at 916 (citing *Dominguez v. Corr. Med. Servs.*, 555 F.3d 543, 550 (6th Cir. 2009)). Additionally, “a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.” *Farmer*, 511 U.S. at 842.

Respondents concede the COVID-19 risk to Petitioner: “The government does not dispute that there is a health risk posed by COVID-19 and that Petitioner is in the category of people identified to be at higher risk for serious health consequences if she contracts COVID-19.” (ECF No. 11, PageID.178.) Rightfully so: the above analysis pertaining to the risk of irreparable harm reveals that the substantial risk to Petitioner is obvious. *Farmer*, 511 U.S. at 842.

Respondents instead argue that Calhoun County Correctional Facility’s precautionary measures preclude a finding of deliberate indifference because government officials cannot be said to have disregarded the risk to Petitioner. As noted above, officials at the Calhoun County Correctional Facility have taken a range of precautionary measures to protect against a potential outbreak. (See

ECF No. 11-3.) But as Plaintiff’s pleadings and the above analysis regarding irreparable injury demonstrate, even with these precautionary measures, in light of Petitioner’s underlying health conditions, she is not ensured anything close to “reasonable safety.” *Farmer*, 511 U.S. at 844. (See ECF No. 6-3, PageID.112 (Declaration of Doctor Golob stating, “[V]ulnerable people, people over the age of 50 and people of any age with lung disease . . . living in an institutional setting . . . are at grave risk of severe illness and death from COVID-19.”); ECF No. 6-1, PageID.87 (Declaration of Infectious Disease Epidemiologist Joseph Amon, stating “The only viable public health strategy available is risk mitigation. . . . [T]he public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety.”).) Based on the record before the Court, the only reasonable response by Respondents is the release of Petitioner; any other response demonstrates a disregard of the specific, severe, and life-threatening risk to Petitioner from COVID-19.

For the same reasons, Petitioner’s continued detention cannot “reasonably relate[] to any legitimate government purpose.” *Bell v. Wolfish*, 441 U.S. 520, 536-39 (1979) (holding that pretrial detention not

reasonably related to a legitimate government purpose must be considered punishment and therefore contrary to the Fifth Amendment). In their response, Respondents do not directly address the justification for Petitioner's continued detention. The Court notes that Petitioner is in civil detention pending removal proceedings pursuant to 28 U.S.C. § 1226(c). Petitioner faces significant risk of death due to COVID-19; accordingly, her continued confinement at the Calhoun County Correctional Facility is both unrelated and contrary to the government purpose of carrying out her removal proceedings.

Both the objective and subjective components are met; Petitioner has shown a likelihood of success on the merits. The Court reiterates that at this early stage in the litigation, Petitioner need not show a certainty of success on the merits. Indeed, "the probability of success that must be demonstrated is inversely proportional to the amount of irreparable injury the movants will suffer absent the stay." *Northeast Ohio Coalition for Homeless and Service Employees Intern. Union, Local 1199*, 467 F.3d at 1009 (6th Cir. 2006). Given the risk and severity of irreparable harm to Petitioner and the weight of public health evidence indicating release

as the only reasonable option under these facts, Petitioner has met her current burden with respect to the merits of her claim.

Respondents nonetheless cite to some authority that release is an inappropriate remedy for Petitioner's claim. *See Glaus v. Anderson*, 408 F.3d 382, 387 (7th Cir. 2005) (noting release is not among the proper remedies for Eighth Amendment deliberate indifference claims, which are limited to injunctive relief for proper treatment and damages); *Heximer v. Woods*, No. 08-14170, 2018 WL 1193368, at *2 (E.D. Mich. Mar. 8, 2018) (noting that "release from custody is not an available remedy for a deliberate indifference claim."). As explained above, Petitioner has shown a likelihood of success on the merits of her claim that given the extraordinary nature of the COVID-19 pandemic, no set of possible confinement conditions would be sufficient to protect her Fifth Amendment rights. Release from custody represents the only adequate remedy in this case, and it is within this Court's broad equitable power to grant it. *See Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 15–16 (1971) ("Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies.")

3. Qualified Immunity

In its supplemental brief, Respondents note that to the extent Petitioner brings a civil rights case, Respondents are entitled to assert a defense of qualified immunity. (ECF No. 19, PageID.317.) Qualified immunity is unavailable as a defense in cases seeking injunctive relief. *See Pearson v. Callahan*, 555 U.S. 223, 242 (2009) (noting that qualified immunity defense is not available in “suits against individuals where injunctive relief is sought in addition to or instead of damages”); *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982) (describing qualified immunity as “immunity from suits for damages”). Because Petitioner here seeks only declaratory and injunctive relief, qualified immunity does not apply.

C. Balance of Equities and Public Interest

When the government opposes the issuance of a temporary restraining order, as Respondents do here, the final two factors—the balance of equities and the public interest—merge, because “the government’s interest is the public interest.” *Pursuing America’s Greatness v. Fed. Election Comm’n*, 831 F.3d 500, 512 (D.C. Cir. 2016) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

The public interest favors Petitioner's release because of the risk that Petitioner's constitutional rights will be deprived absent an injunction. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *G & V Lounge Inc. v. Mich. Liquor Control Comm.*, 23 F.3d 1071, 1079 (6th Cir.1994).

Additionally, Petitioner's release will protect public health. Given the highly unusual and unique circumstances posed by the COVID-19 pandemic and ensuing crisis, "the continued detention of aging or ill civil detainees does not serve the public's interest." *Basank*, 2020 WL 1481503, at *6; *see also Fraihat v. U.S. Imm. and Customs Enforcement*, 5:19 Civ. 1546, ECF No. 81-11 (C.D. Cal. Mar. 24, 2020) ("the design and operation of detention settings promotes the spread of communicable diseases such as COVID-19"); *Castillo v. Barr*, CV-20-00605-TJH (C.D. Cal. 2020). Protecting public health and safety is in the public interest. *See Neinast v. Bd. Of Trustees*, 346 F.3d 585, 592 (6th Cir. 2003) (recognizing public health and safety as legitimate government interests).

Respondents argue that public interest favors Petitioner's continued detention because "the public interest in enforcement of the

United States' immigration laws is significant.” (ECF No. 11, PageID.187 (citing *United States v. Martinez-Fuerte*, 428 U.S. 543, 556–58 (1976); *Blackie's House of Beef, Inc. v. Castillo*, 659 F.2d 1211, 1221 (D.C. Cir. 1981) (“The Supreme Court has recognized that the public interest in enforcement of the immigration laws is significant.”))).

Respondents point to only one immigration law that will see continued enforcement by denying relief to Petitioner. That law is 8 U.S.C. § 1226(c), and it authorizes Petitioner's continued detention. But as set forth above, Petitioner's continued detention is in violation of the United States Constitution, to which 8 U.S.C. § 1226(c) must give way.

The enforcement of the remainder of U.S. immigration laws against Petitioner will continue unabated should the Court grant Petitioner relief. A hearing on Petitioner's request for cancellation of removal is scheduled for April 14, 2020. (ECF No. 11, PageID.170). Respondents do not argue that Petitioner's release will jeopardize her appearance at that hearing, nor do they argue that Petitioner's release will undermine her removal from this country, should Petitioner's defense fail and should conditions allow such removal.

The public interest and balance of equities demand that the Court protect Petitioner's constitutional rights and the public health over the continued enforcement of a detention provision that, as applied to Petitioner, is unconstitutional. The remaining factors counsel granting Petitioner relief.

Because all four factors weigh in favor of issuing emergency injunctive relief, Petitioners motion for a temporary restraining order is granted.

IV. Conclusion

For the reasons stated above, Petitioner's Application for a Temporary Restraining Order is GRANTED IN PART. Respondent Adducci is ORDERED to release Petitioner on April 6, 2020 on her own recognizance. Petitioner will be subject to the following restrictions: Petitioner is subject to fourteen days of home quarantine; Petitioner must comply with all Michigan Executive Orders; and Petitioner must appear at all hearings pertaining to her removal proceedings. Respondents may impose other reasonable nonconfinement terms of supervision.

Respondents are further RESTRAINED from arresting Petitioner for civil immigration detention purposes until the State of Emergency in

Michigan (related to COVID-19) is lifted or until further Court Order stating otherwise.

The Temporary Restraining Order will expire on April 17, 2020, at 6:30 p.m. No later than April 10, 2020, at 12:00 p.m., Respondents must show cause why this Order should not be converted to a preliminary injunction. Petitioner may file a response no later than April 16, 2020, at 12:00 p.m.

IT IS SO ORDERED.

Dated: April 6, 2020
Ann Arbor, Michigan

s/Judith E. Levy
JUDITH E. LEVY
United States District Judge

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was served upon counsel of record and any unrepresented parties via the Court's ECF System to their respective email or First Class U.S. mail addresses disclosed on the Notice of Electronic Filing on April 6, 2020.

s/William Barkholz
WILLIAM BARKHOLZ
Case Manager