

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

**Tre McPherson, Pattikate Williams-Void,
John Doe, John Roe, and Thomas Caves, on
behalf of themselves and all others similarly
situated,**

Plaintiffs-Petitioners,

V.

Ned Lamont and Rollin Cook, in their official capacities,

Defendants-Respondents.

[illegible]

Case No. 20-cv-534

April 20, 2020

IMMEDIATE RELIEF SOUGHT

**CLASS ACTION COMPLAINT FOR DECLARATORY
AND INJUNCTIVE RELIEF AND PETITION FOR WRITS OF HABEAS CORPUS**

INTRODUCTION

1. Plaintiffs-Petitioners (“Plaintiffs”) are individuals held at Connecticut Department of Correction (“DOC”) facilities, many of whom have a serious pre-existing medical condition or are in an age group which the United States Centers for Disease Control (“CDC”) has determined puts them at significantly higher risk of severe disease and death if they contract Coronavirus Disease 19 (“COVID-19”). The conditions of confinement at DOC facilities across the state create a heightened and unreasonable risk of COVID-19 for any person confined at the jail and a substantial risk of severe illness or death for those who are older and/or medically vulnerable to COVID-19. Plaintiffs bring this class action seeking immediate release of all individuals 50 and older and those with medical conditions that place them at heightened risk of severe illness or death from COVID-19. These individuals are members of the “Medically Vulnerable Pre-adjudication Subclass” or the “Medically Vulnerable Post-adjudication Subclass.” Release will remove the Medically Vulnerable Subclasses from a life-threatening situation and allow Defendants-Respondents to implement social distancing measures and other CDC public-health guidelines for those remaining in DOC facilities. Plaintiffs also seek injunctive relief on behalf of two classes that together comprise all individuals currently held in DOC facilities: the Pre-adjudication Class of those incarcerated people held while awaiting adjudication of their charges, and the Post-adjudication Class of those incarcerated people who are serving a criminal sentence. Plaintiffs ask the Court to order Defendants-Respondents to comply with the safety and health guidelines that prevent or minimize the spread of the virus for those confined in DOC facilities. It is unconscionable that Defendants-Respondents have not yet implemented CDC guidelines to maximize social distancing, increased hygiene, access to personal protective equipment (“PPE”), and appropriate medical treatment for those infected. Indeed, Defendant-Respondent Cook’s

response to the crisis has been to simply transfer members of the Classes who had tested positive for COVID-19 to isolation units in Northern Correctional Institution (“Northern”), a “supermax” prison not intended or designed to serve as a medical correctional facility. He then failed to confirm that transferred class members would receive the level of care recommended by the CDC and failed to take steps to provide adequate hygiene, sanitation, or social distancing for the remaining incarcerated people in DOC facilities.

2. Prisons and jails are quickly becoming the epicenter of COVID-19 in cities throughout the country, including New York, Chicago, and Philadelphia. DOC is quickly joining these ignoble ranks due to the inherent congregate nature of its facilities, as exacerbated by its reactive, haphazard, and inconsistent approach to dealing with the virus. As demonstrated by the exponential spread of COVID-19 throughout DOC facilities over the past three weeks, current conditions continue to create an extreme risk for rapid, uncontrollable spread of COVID-19 throughout the system with grave outcomes for both the incarcerated population and the surrounding communities. Although in April, DOC began moving COVID-19-positive incarcerated people to Northern to isolate the positive cases from the rest of the incarcerated population, these efforts are insufficient. Pervasive fear of Northern has deterred people from reporting symptoms; not all COVID-19-positive incarcerated people have been transferred; some have not been transferred immediately; others have been returned prematurely; and those left behind have not been screened, quarantined, or otherwise protected. Meanwhile, people detained in other DOC facilities remain unable to comply with CDC guidelines to practice social distancing, maintain proper personal hygiene, frequently disinfect their spaces, or use appropriate PPE. In fact, responsive measures within DOC continue to differ not only day by day, but facility by facility, building by building, and block by block.

3. A substantial number of people currently held at DOC facilities—members of the Medically Vulnerable Subclasses—face serious risks of life-threatening illness due to their age and/or underlying medical conditions. Plaintiffs seek writs of habeas corpus for members of the Medically Vulnerable Subclasses. Habeas relief is essential and proper to prevent unnecessary loss of life.

4. For all individuals held in DOC facilities—the Classes—Defendants-Respondents must substantially alter conditions to comply with the CDC guidelines for social distancing and enhanced sanitation and hygiene practices. Plaintiffs ask the Court to certify the Class and to order Defendants-Respondents to implement a plan that allows DOC facilities to comply with CDC guidelines for social distancing, hygiene and sanitation practices, PPE, and adequate medical care. To aid the Court in enforcing this order, Plaintiffs ask the Court to appoint a public-health expert to 1) evaluate the Defendants-Respondents' proposed program, and 2) to confirm that Defendants-Respondents properly identify and release members of the Medically Vulnerable Subclasses.

5. Accordingly, Plaintiffs, on behalf of the Classes and the Medically Vulnerable Subclasses, bring this action and request immediate release of all members of the Medically Vulnerable Subclasses. Plaintiffs and the Classes also ask this Court to order Defendants-Respondents to cure the unsafe conditions at DOC facilities by implementing procedures that comply with CDC guidelines. If this Court does not grant immediate release to the Medically Vulnerable Subclasses and injunctive relief to the Classes, Plaintiffs request a hearing as soon as possible. Given the rapid exponential spread of COVID-19, there is no time to spare.

I. JURISDICTION AND VENUE

6. Plaintiffs bring this putative class action pursuant to 22 U.S.C. § 2241, 42 U.S.C. § 1983, and 28 U.S.C. §§ 2201, 2202, for relief from both detention and conditions of confinement

that violate the Eighth and Fourteenth Amendments.

7. This Court has subject matter jurisdiction over these claims pursuant to 28 U.S.C. § 2241 (habeas corpus), 28 U.S.C. § 1651 (All Writs Act), 28 U.S.C. § 1343(a) (civil rights jurisdiction), and 28 U.S.C. § 1331 (federal question jurisdiction).

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

II. PARTIES

9. Plaintiff Tre McPherson is a pretrial detainee at Bridgeport Correctional Center held for lack of a \$5,100 bond. Defendants-Respondents house him in an open dormitory with fifty-seven other men. Many men in his dormitory have reported symptoms similar to a head cold, including Mr. McPherson, who recently also lost his sense of smell. These are symptoms of COVID-19. At least one other man was very sick and removed from the dormitory.

10. Plaintiff Pattikate Williams-Void is a pretrial detainee at York Correctional Institute held for lack of a \$75,000 bond. She has hypertension and has been diagnosed as pre-diabetic. These underlying medical conditions put Ms. Williams-Void at a high risk of life-threatening complications should she contract COVID-19.

11. Plaintiff John Doe is above the age of 70 and is a prisoner serving a sentence of incarceration. He has HIV and hepatitis C, and requires regular dialysis for kidney disease. These underlying medical conditions put Mr. Doe at high risk of life-threatening complications should he contract COVID-19. In disregard of these risk factors, Defendants-Respondents house Mr. Doe with a cellmate.

12. Plaintiff John Roe is above the age of 50 and is a prisoner serving a sentence of incarceration. He has HIV, which, along with his age, puts him at high risk of life-threatening complications should he contract COVID-19. In disregard of these risk factors, Defendants-

Respondents house Mr. Roe in an open dormitory with more than ninety other people sleeping in bunkbeds in close proximity to one another.

13. Plaintiff Thomas Caves is a prisoner serving a sentence of incarceration at Corrigan-Radgowski Correctional Institute. Defendants-Respondents house him with a cellmate and his cell is not cleaned. Mr. Caves shares showers, phones, and common space with more than eighty other men housed in his unit. One person who contracted COVID-19 and fell ill in Mr. Caves' unit was simply locked in his cell, with his cellmate, for 15 days.

14. Defendant-Respondent Ned Lamont is the governor of state of Connecticut. He is sued in his official capacity. Governor Lamont and the state of Connecticut control and operate the DOC facilities through Defendant-Respondent Commissioner Rollin Cook. The state of Connecticut currently has immediate custody over Plaintiffs McPherson, Williams-Void, Doe, Roe, Caves, and all other putative class members.

15. Defendant-Respondent Rollin Cook is the commissioner of the Connecticut Department of Correction. Defendant-Respondent Cook currently has immediate custody over Plaintiffs-Petitioners McPherson, Williams-Void, Doe, Roe, Caves, and all other putative class members. Defendant-Respondent Cook is a policymaker for the state of Connecticut. Defendant-Respondent Cook is sued in his official capacity.

III. FACTUAL ALLEGATIONS

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

16. We are in the midst of the most significant pandemic in generations.¹ The lethality

¹ John M. Barry, *The Single Most Important Lesson from the 1918 Influenza*, N.Y. TIMES (Mar. 17, 2020), <https://cutt.ly/PtQ5uAZ> (opinion piece by author of "The Great Influenza: The Story of the Deadliest

rate of COVID-19, the serious respiratory disease caused by this coronavirus, is estimated to be between 1 and 6%, about tenfold higher than that observed from a severe seasonal influenza that kills thousands a year.² As of 4 p.m. on April 20, 2020, there were 19,815 confirmed cases of COVID-19 in Connecticut and 1,331 COVID-19-related deaths.³ The virus is spreading exponentially.⁴ In fact, the number of confirmed COVID-19 cases in Connecticut jumped over 21% just between April 5 and April 6, 2020.⁵

17. The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.⁶ There is no vaccine against COVID-19, and there is no known medication to prevent or treat infection.⁷ Social distancing—deliberately keeping at least six feet of space between persons to avoid spreading illness⁸—and a vigilant hygiene regimen, including washing hands frequently and thoroughly with

Pandemic in History,” noting comparison between current COVID-19 outbreak and the 1918 influenza outbreak widely considered one of the worst pandemics in history).

² As of April 20, 2020, there were 2,470,410 confirmed cases globally, with 169,595 deaths and 645,335 recoveries. Johns Hopkins University of Medicine, *Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering at Johns Hopkins University*, <https://cutt.ly/StEyn2U>; Exhibit A, Expert Declaration of Dr. Jonathan Louis Golob, M.D. (“Golob Decl.”), ¶ 4. Dr. Golob is an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, and a specialist in infectious diseases and internal medicine with a subspecialty in infections in immunocompromised patients.

³ *COVID-19 Update April 20, 2020*, available at <https://portal.ct.gov/-/media/Coronavirus/CTDPHCOVID19summary4202020.pdf?la=en>.

⁴ See Golob Decl. ¶ 2.

⁵ Alex Putterman and Eliza Fawcett, *Connecticut COVID-19 curve flatter than expected, but researchers predict 5,500 fatalities by August*, HARTFORD COURANT (Apr. 6, 2020), <https://cutt.ly/2t3Cxau>.

⁶ Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, <https://cutt.ly/ztRAo0X>.

⁷ World Health Organization, *Coronavirus*, <https://cutt.ly/ztWYf7e> (“At this time, there are no specific vaccines or treatments for COVID-19.”); Declaration of Dr. Robert B. Greifinger, M.D., ¶ 8, *Dawson v. Asher*, 20-cv-409 (W.D. Wash. Mar. 16, 2020), ECF No. 4 (“Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19.”).

⁸ Johns Hopkins University, *Coronavirus, Social Distancing and Self-Quarantine*, <https://cutt.ly/VtYYiDG>.

soap and water, are the only known measures for protecting against transmission of COVID-19.⁹ Because the coronavirus spreads among people who do not show symptoms, staying away from people is the best way to prevent infection.¹⁰ *Everyone*—including the staff at DOC facilities—has to act as if *everyone* has the disease.

18. COVID-19 can cause severe damage to lung tissue, including a permanent loss of respiratory capacity, and it can damage tissue in other vital organs, such as the heart and liver.¹¹

19. People over the age of fifty face a greater risk of serious illness or death from COVID-19.¹² In a February 29, 2020 preliminary report, individuals age 50-59 had an overall mortality rate of 1.3%; 60-69-year-olds had an overall 3.6% mortality rate, and those 70-79 years old had an 8% mortality rate.¹³

20. People of any age also are at an elevated risk if they suffer from certain underlying medical conditions, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, or asthma.¹⁴ A report from

⁹ Declaration of Dr. Jonathan Louis Golob, MD, ¶ 8, *Dawson v. Asher*, 20-cv-409 (W.D. Wash. Mar. 16, 2020), ECF No. 5.

¹⁰ Exhibit B, Expert Declaration of Dr. Jonathan Giftos, M.D. (“Giftos Decl.”), ¶¶ 8–9. Dr. Giftos is the Medical Director of Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine. He is the former Attending Physician and the Clinical Director of Substance Use and Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island; Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. TIMES (Mar. 31, 2020), <https://cutt.ly/6t4wchX>.

¹¹ Golob Decl. ¶¶ 4, 9.

¹² Golob Decl. ¶ 14.

¹³ *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths* Chart, <https://cutt.ly/ytEimUQ> (data analysis based on WHO China Joint Mission Report).

¹⁴ Golob Decl. ¶¶ 3, 14.

the World Health Organization (“WHO”) estimated the mortality rate of 13.2% for COVID-19 patients with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.¹⁵

21. In many people, COVID-19 causes fever, cough, and shortness of breath.¹⁶ Most people in high-risk categories who develop serious illness will need advanced support.¹⁷ This requires highly specialized equipment that are in limited supply, such as ventilators, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians.¹⁸

22. The need for care, including intensive care, and the risk of death, is much higher for COVID-19 infection than for influenza.¹⁹ 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.²⁰ For people in the highest-risk populations, the fatality rate of COVID-19 infection is about 15 percent.²¹ Patients who do not die from serious cases of COVID-19 may face prolonged recovery periods, including extensive rehabilitation from neurologic damage, loss of digits, and loss of respiratory capacity.²²

¹⁵ *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), at 12, <https://cutt.ly/xtEokCt>.

¹⁶ Golob Decl. ¶ 5.

¹⁷ *Id.* at ¶ 8.

¹⁸ *Id.*

¹⁹ *Id.* at ¶ 4.

²⁰ *Id.* See also Betsy McKay, *Coronavirus vs. Flu Which Virus is Deadlier*, WALL ST. J. (Mar. 10, 2020, 12:49 p.m.), <https://cutt.ly/itEmi8j>.

²¹ Golob Decl. ¶ 4.

²² *Id.*

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

23. People in congregate environments—places where people live, eat, and sleep in close proximity—face increased danger of coronavirus infection and COVID-19, as already evidenced by the rapid spread of the virus on cruise ships²³ and in nursing homes.²⁴ It is virtually impossible for people who are confined in prisons, jails, and detention centers to engage in the necessary social distancing and hygiene required to mitigate the risk of transmission of the disease.²⁵

24. “Correctional settings increase the risk” of contracting COVID-19 because in prison, “there are high numbers of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others,”²⁶ such that “there are more people susceptible to getting infected congregated together in a context in which fighting the spread of an infection *is nearly impossible*.”²⁷

25. This increased risk is present and apparent in the DOC facilities. As elsewhere,

²³ The CDC is currently recommending that travelers defer cruise ship travel worldwide. “Cruise ship passengers are at increased risk of person-to-person spread of infectious diseases, including COVID-19.” *COVID and Cruise Ship Travel*, Centers for Disease Control and Prevention, <https://cutt.ly/7tEEQvT>.

²⁴ The CDC notes that long-term care facilities and nursing homes pose a particular risk because of “their congregate nature” and the residents served. *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes*, Centers for Disease Control and Prevention, <https://cutt.ly/7tEEIT>; Golob Decl. ¶ 12.

²⁵ Exhibit C, Expert Declaration of Dr. Josiah Rich, M.D., MPH (“Rich Decl.”), ¶¶ 8, 10. Dr. Rich, an infectious disease specialist, is a Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University and the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital; Golob Decl. ¶ 13.

²⁶ Giftos Decl. ¶ 12.

²⁷ *Id.* ¶ 13 (emphasis added). See also Letter from Johns Hopkins Faculty, *supra* note 8; Declaration of Dr. Jaimie Meyer, *Velesaca v. Decker*, 20-cv-1803 (S.D.N.Y. Mar. 16, 2020), ECF No. 42 (noting, *inter alia*, that jail environments have reduced prevention opportunities, increased susceptibility, and are often poorly equipped to diagnose and manage outbreaks of infection disease).

incarcerated people in Connecticut suffer from disproportionately high rates of chronic illness. Nationwide, about forty percent of incarcerated people have at least one chronic illness, and almost all chronic illnesses are more common among incarcerated populations.²⁸ Many of these illnesses, such as hypertension (30.2% compared to 18.1% in the general population), other heart problems (9.8% compared to 2.9% in the general population), asthma (14.0% compared to 10.2% in the general population), and diabetes (9.0% compared to 6.5% in the general population),²⁹ are associated with more severe cases of COVID-19 and poorer outcomes.³⁰ In Connecticut, DOC healthcare staff have reported that the housed population suffers high rates of infection leading to chronic illness, such as hepatitis C.³¹ In addition, in 2012, the most recent year for which data on HIV in Connecticut prisons is publicly available, the HIV infection rate was more than 3.5 times higher in incarcerated populations³² than the HIV rate in the state as a whole.³³

26. In addition, Connecticut's prison population is aging. Five hundred ninety-six of the people in state custody are 50 or older and therefore are at a higher risk for severe complications

²⁸ See, e.g., The Center for Prisoner Health and Human Rights, *Chronic and Infectious Diseases in Justice-Involved Populations* (2020), <https://cutt.ly/nt4uO2F>; Vera Institute of Justice, *On Life Support: Public Health in the Age of Mass Incarceration* (2014), available at <https://cutt.ly/Ft4uAIJ>.

²⁹ Laura M. Maruschak & Marchus Berzofsky, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012*, Dep't. of Justice: Bureau of Justice Statistics (Feb. 2015), <https://cutt.ly/Lt4uG5a>.

³⁰ Centers for Disease Control and Prevention, *People Who are at a Higher Risk for Severe Illness, Coronavirus Disease 2019* (Mar. 2020), available at <https://cutt.ly/jt3Cm4T>.

³¹ Josh Kovner, *Prison Doctors, Nurses Say Health Care Behind Bars Has Ruptured*, Hartford Courant, Sept. 18, 2020, <https://cutt.ly/st3CWpC>.

³² Compare Laura M. Maruschak & Marchus Berzofsky, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012*, Dept. of Justice: Bureau of Justice Statistics (Feb. 2015), at 16, available at <https://cutt.ly/dt4uN7i>, with U.S. Dep't of Justice, *Prisoners in 2012, Advance Counts* (Jul. 2013), at 3, available at <https://cutt.ly/9t4u0T5>.

³³ Compare Centers for Disease Control and Prevention, *Prevalence of Diagnosed and Undiagnosed HIV Infection—United States, 2008–2012* (June 26, 2015), available at <https://cutt.ly/Lt4u3jq>, with Connecticut Department of Public Health, *Estimated Populations in Connecticut as of July 1, 2012*, available at <https://cutt.ly/8t3CRNB>.

from a COVID-19 infection.³⁴ These individuals pose the least risk to the public, yet are most at risk of serious illness or death. At the same time, the high risk presented to older people by COVID-19 is “of particular concern for inmate populations, since prisoners’ physiological age averages 10 to 15 years older than their chronological age.”³⁵

27. Generally, it has proven difficult to implement CDC guidelines in a correctional setting, and incarcerated people already are dying nationwide as a result.³⁶ This is demonstrated by dramatic outbreaks at Rikers Island in New York City and at the Cook County Jail in Chicago, where the transmission rate for COVID-19 is estimated to be the highest in the world.³⁷ The CDC also warns of “community spread”: where the virus spreads easily and sustainably within a community where the source of infection is unknown.³⁸

28. Flu outbreaks regularly occur in jails; during the H1N1 epidemic in 2009, jails and prisons had a disproportionately high number of cases.³⁹

³⁴ See Exhibit D, Affidavit of Brie M. Williams, M.D. (“Williams Aff.”), ¶ 7. Dr. Williams is a Professor of Medical at the University of California, San Francisco (“UCSF”) in the Geriatrics Division, Director of UCSF’s Amend: Changing Correctional Culture Program, and the Director of UCSF’s Criminal Justice & Health Program.

³⁵ *Id.* at ¶ 11 (emphasis in original).

³⁶ See *COVID-19 Coronavirus*, Federal Bureau of Prisons, <https://cutt.ly/itRSDNH>; see also, e.g., Lara Salahi, *2nd Mass. Inmate Dies of Coronavirus*, NBC BOS. (Apr. 5, 2020); Josiah Bates, *New York’s Rikers Island Jail Sees First Inmate Death From COVID-19*, TIME (Apr. 6, 2020); Megan Crepeau and Jason Meisner, *Cook County Jail detainee dies of COVID-19*, CHI. TRIB. (Apr. 7, 2020 6:30 a.m.).

³⁷ These numbers likely underestimate the infection rate on Rikers Island, as they do not include the number of people who contracted COVID-19 on Rikers Island but have already been released. The rates of infection rely on publicly released data collected by the Legal Aid Society. See Legal Aid Society, *Analysis of COVID-19 Infection Rate in NYC Jails* (last visited Apr. 8, 2020, 1:10 p.m.), <https://cutt.ly/RtYTbWd>. See also Timothy Williams and Danielle Ivory, *Chicago’s Jail Is Top U.S. Hot Spot as Virus Spreads Behind Bars*, N.Y. TIMES (Apr. 8, 2020 6:22 p.m.), <https://cutt.ly/ot3CAuk>; Golob Decl. ¶ 12.

³⁸ *How Coronavirus Spreads*, Centers for Disease Control and Prevention, <https://cutt.ly/jtEE9vG>.

³⁹ See, e.g., Golob Decl., ¶ 13. The H1N1 “swine flu” pandemic outbreak spread dramatically in jails and prisons in 2010, but that strain of virus had a low fatality rate because of the characteristics of the virus—COVID-19’s fatality rate is far higher. See David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, PRISON LEGAL NEWS (Feb. 15, 2010), <https://cutt.ly/ytRSkuX>.

29. Numerous public health experts, including Dr. Golob,⁴⁰ Dr. Rich,⁴¹ Dr. Gregg Gonsalves,⁴² Ross MacDonald,⁴³ Dr. Marc Stern,⁴⁴ Dr. Oluwadamilola T. Oladeru and Adam Beckman,⁴⁵ Dr. Anne Spaulding,⁴⁶ Homer Venters,⁴⁷ and the faculty at Johns Hopkins schools of nursing, medicine, and public health,⁴⁸ have strongly cautioned that people booked into and held in jails likely will face serious harm due to the COVID-19 pandemic.

30. Risk mitigation is the only viable strategy to combat the spread of COVID-19 and prevent serious harm or death to class members.⁴⁹ Even with the most comprehensive plan to address the spread of COVID-19 in detention facilities, a key part of an effective risk mitigation strategy is the release of individuals at high risk of severe disease if infected with COVID-19. Immediate release of the medically vulnerable population not only protects them from transmission of COVID-19, but also mitigates risk for people in the DOC facilities. A population decrease would allow for better social distancing and increased availability of hygiene products, PPE, and access to medical care for those who remain, all of which decreases the COVID-19 risks

⁴⁰ Golob Decl. ¶¶ 13–14.

⁴¹ Rich Decl. ¶¶ 15–17.

⁴² Kelan Lyons, *Elderly Prison Population Vulnerable to Potential Coronavirus Outbreak*, CONN. MIRROR (Mar. 11, 2020), <https://cutt.ly/BtRSxCF>.

⁴³ Craig McCarthy and Natalie Musumeci, *Top Rikers Doctor: Coronavirus 'Storm is Coming,'* N.Y. POST (Mar. 19, 2020), <https://cutt.ly/ptRSnVo>.

⁴⁴ Marc F. Stern, MD, MPH, *Washington State Jails Coronavirus Management Suggestions in 3 "Buckets,"* Washington Assoc. of Sheriffs & Police Chiefs (Mar. 5, 2020), <https://cutt.ly/EtRSm4R>.

⁴⁵ Oluwadamilola T. Oladeru, et al., *What COVID-19 Means for America's Incarcerated Population – and How to Ensure It's Not Left Behind*, HEALTH AFFAIRS BLOG (Mar. 10, 2020), <https://cutt.ly/QtRSYNA>.

⁴⁶ Anne C. Spaulding, MD MPH, *Coronavirus COVID-19 and the Correctional Jail*, EMORY CENTER FOR THE HEALTH OF INCARCERATED PERSONS (Mar. 9, 2020).

⁴⁷ Madison Pauly, *To Arrest the Spread of Coronavirus, Arrest Fewer People*, MOTHER JONES (Mar. 12, 2020), <https://cutt.ly/jtRSPnk>.

⁴⁸ Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Md., Mar. 25, 2020, <https://cutt.ly/stERiXk>.

⁴⁹ See Rich Decl. ¶ 13.

for the incarcerated and the facility staff.⁵⁰

31. Release of the most vulnerable people from custody also reduces the burden on the region's healthcare infrastructure by reducing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.⁵¹

32. In the United States, jail administrators in other jurisdictions have concluded that widespread jail release is a necessary and appropriate public health intervention, including Cuyahoga County, Ohio⁵²; San Francisco, California⁵³; Jefferson County, Colorado⁵⁴; Montgomery, Alabama⁵⁵; and the States of New Jersey⁵⁶ and Pennsylvania,⁵⁷ among others.

C. DOC's Reactive, Backwards-Looking Approach to Handling the Pandemic Has Exacerbated the Crisis

33. Even before the COVID-19 outbreak, Connecticut has long struggled to provide sufficient medical services to the people it incarcerates.

34. First, DOC's medical arm is extremely short-staffed. In July 2019, the *Connecticut Mirror* reported that DOC has 309 nurses on staff to serve 13,320 prisoners, or one nurse for every

⁵⁰ *Id.* at ¶ 27.

⁵¹ Rich Decl. ¶ 17.

⁵² Scott Noll, *Cuyahoga County Jail Releases Hundreds of Low-Level Offenders to Prepare for Coronavirus Pandemic*, (Mar. 20 2020 6:04 p.m.), <https://cutt.ly/CtRSHkZ>.

⁵³ Megan Cassidy, *Alameda County Releases 250 Jail Inmates Amid Coronavirus Concerns, SF to Release 26*, S.F. CHRONICLE (Mar. 20, 2020), <https://cutt.ly/0tRSVmG>.

⁵⁴ Jenna Carroll, *Inmates Being Released Early From JeffCo Detention Facility Amid Coronavirus Concerns*, KDVR COLO. (Mar. 19, 2020 2:29 pm.), <https://cutt.ly/UtRS8LE>.

⁵⁵ *See In Re: COVID-19 Pandemic Emergency Response*, Administrative Order No. 4, Montgomery County Circuit Court (Mar. 17, 2020).

⁵⁶ Erin Vogt, *Here's NJ's Plan for Releasing Up to 1,000 Inmates as COVID-19 Spreads* (Mar. 23, 2020), <https://cutt.ly/QtRS53w>.

⁵⁷ *See* Governor Tom Wolf, *Gov. Wolf: Department of Corrections to Establish Temporary Program to Reprieve Sentences of Incarceration* (Apr. 10, 2020), <https://www.governor.pa.gov/newsroom/gov-wolf-department-of-corrections-to-establish-temporary-program-to-reprieve-sentences-of-incarceration/>.

43 prisoners.⁵⁸ For medical providers, including doctor and physician assistants, the DOC employs only one for every 579 prisoners.⁵⁹

35. Little has changed since that report. In early 2020, Cheshire Correctional Institution and Corrigan-Radgowski Correctional Center reported employing 29 and 27 nurses, respectively, or 39 incarcerated people per nurse at Cheshire and 40 at Corrigan-Radgowski. In February 2020, Defendant-Respondent Cook told members of the Black and Puerto Rican Legislative Caucus that there were 139 healthcare positions vacant out of 843 budgeted—or one out of six.⁶⁰

36. In March, with the threat of COVID-19 looming, a DOC spokesperson suggested that facilities can manage shortages by scheduling medical employees for twelve hours at a time in an emergency.⁶¹ However, the *Connecticut Mirror* reported that healthcare staff were already logging what would appear to be the maximum possible overtime *before* the pandemic, sometimes staying on shift for sixteen to twenty-four hours a day.⁶² And, as of early February, head nurses, nurses, and licensed nurse practitioners were among the twenty top wage earners in the DOC based on their overtime pay; at least three nursing staff were making twice their annual pay in overtime.⁶³

37. The fact that the DOC is short-staffed by nearly 140 people to provide ordinary healthcare needs at its facilities is alarming because retirees and medical students are already being

⁵⁸ Jenna Carlesso and Kelan Lyons, *One Year after DOC Took Over Inmate Healthcare, Troubles Persist*, CONN. MIRROR (July 2, 2019), <https://cutt.ly/Wt3CL0Q>.

⁵⁹ *Id.*

⁶⁰ Lisa Backus, *Staffing Shortage Creates ‘Dangerous’ Situation in CT Prisons*, CONN. POST (Feb. 3, 2020), <https://cutt.ly/Mt3CXEm>.

⁶¹ Kelan Lyons, *supra* note 42.

⁶² Jenna Carlesso and Kelan Lyons, *supra* note 58

⁶³ Lisa Backus, *supra* note 60.

called to aid overwhelmed medical staff in regions where COVID-19 is rampant.⁶⁴ DOC medical staff have sounded the alarm about possible systemic failure. Dr. Gerald Valletta, the primary physician at Garner and Manson Youth Institution in Cheshire, told the *Hartford Courant* that “[t]he more people get sick and call out [due to COVID-19 health concerns], the more burdened staff will be. We were already facing a huge shortage.”⁶⁵ Debra Cruz, head nurse at Cheshire, expressed similar concerns, suggesting that even mandating 16-hour shifts, as permitted in the workers’ contract, would not guarantee adequate healthcare. She told the *Hartford Courant* on March 11 that, “[w]e’re all just holding our breath and hoping this passes us by.”⁶⁶

38. Initially, DOC’s only plan to address COVID-19 was a repurposed 2007 policy for flu outbreaks.⁶⁷ On March 11, spokesperson Karen Martucci doubled down on the outdated plan in a press interview. “This isn’t new for us. We quarantine for the flu every year,” she said. “We didn’t have to create a pandemic plan. This was already created.”⁶⁸ When asked about prisoner releases in response to COVID-19, she responded, “Overcrowding is not a concern for our agency. We have space to use.”⁶⁹

39. On March 20, the DOC drafted a COVID-specific COVID-19 Operational Response Plan Phase 1.⁷⁰ On March 24, Governor Lamont refused to consider releasing anyone

⁶⁴ Selena Simmons Duffin, *States Get Creative to Find and Deploy More Workers in COVID-19 Fight*, NPR (Mar. 25, 2020), <https://cutt.ly/Pt3CVIZ>.

⁶⁵ Eliza Fawcett, *With COVID-19 Threat Looming, State Prisons and Jails are on Edge*, HARTFORD COURANT (Mar. 28, 2020), <https://cutt.ly/0t3CB3f>.

⁶⁶ Kelan Lyons, *supra* note 42.

⁶⁷ See Conn. Dep’t of Correction, *Pandemic Influenza Response Plan* (Feb. 14, 2007), available at <https://cutt.ly/Qt3CMEy>.

⁶⁸ Kelan Lyons, *supra* note 42.

⁶⁹ *Id.*

⁷⁰ See Conn. Dep’t of Correction, *COVID-19 Operational Response Plan 1* (Mar. 20, 2020), available at <https://cutt.ly/Kt3C2m7>.

in state custody but offered that “[w]e are going to do everything we can to make sure that anybody who may be at risk of being a carrier is segregated or quarantined in a separate area.”⁷¹

40. Despite these assurances, on March 30, 2020 the first incarcerated person at a DOC facility tested positive.⁷² By April 2, **16** DOC staff members and **8** incarcerated people had tested positive for COVID-19. By April 6, both those numbers more than doubled, to **32** DOC staff members and **21** incarcerated people. By April 7, these numbers had grown exponentially: **41** DOC staff members and **44** incarcerated people had tested positive, with **53** prisoner test results still pending.

41. By April 8, the number of incarcerated people at DOC facilities who tested positive grew to **46** across 13 different DOC facilities.⁷³ That day, in an abrupt about-face, Defendants-Respondents announced plans to transfer all incarcerated people who had tested positive for COVID-19 to Northern.⁷⁴ The initial transfer involved 47 incarcerated people.

42. Notwithstanding these transfers, the number of positive cases in DOC facilities has continued to rise exponentially. As of April 13, 2020, they stood at **104** staff and **166** incarcerated people.⁷⁵ That day marked a somber milestone: the first person in DOC custody to die from COVID-19.⁷⁶ He was over 60 and had been serving a two-year sentence.⁷⁷

⁷¹ Kelan Lyons, *Lamont Says No Prison Releases Because of COVID-19 Despite Pressure From Advocates*, CONN. MIRROR (Mar. 24, 2020), <https://cutt.ly/Jt3C8v8>.

⁷² Connecticut State Dep’t of Correction, *First Department of Correction Offender Tests Positive for the COVID-19 Virus* (Mar. 30, 2020), available at <https://cutt.ly/Xt3C4BD>.

⁷³ See Connecticut State Dep’t of Correction, Health Information and Advisories: Coronavirus Information, available at <https://cutt.ly/Jt3C5Mj> (accessed Apr. 8, 2020).

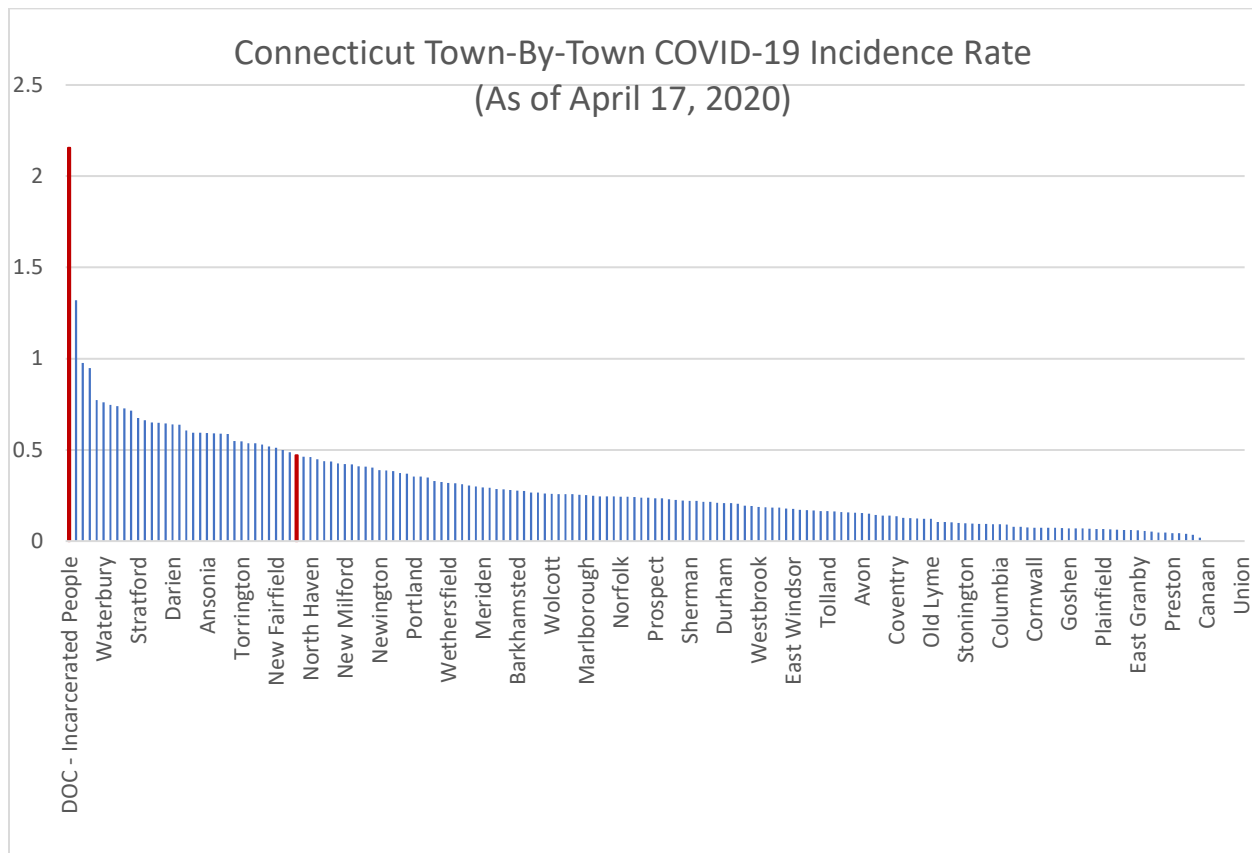
⁷⁴ *State Moving Coronavirus-Positive Inmates to Northern Correctional Institute*, NBC CONN. (Apr. 8, 2020), <https://cutt.ly/pt3VqXT>.

⁷⁵ See Connecticut Dep’t of Correction, *Covid-19 Tracker*, <https://cutt.ly/Nt3Ves2> (last visited Apr. 13, 2020).

⁷⁶ *First Conn. Inmate Dies of Coronavirus: DOC*, NBC CONN. (Apr. 13, 2020), <https://cutt.ly/St3Vrbm>.

⁷⁷ *Id.*

43. The most recent figures DOC released, on April 20, 2020, showed **202** staff and **293** incarcerated people who have tested positive. DOC's infection rate—considering incarcerated people only, not incarcerated people and staff—is multipliers higher than that of anywhere else in Connecticut, as seen below⁷⁸:



⁷⁸ Incidence rates in DOC (for incarcerated people only) and each of Connecticut's 169 towns have been calculated using the following inputs: Connecticut State Dep't of Public Health, Estimated Populations in Connecticut as of July 1, 2018, *available at* <https://cutt.ly/9ywmX9E> (last accessed Apr. 20, 2020); Connecticut State Dep't of Public Health, COVID 19 Update April 17, 2020, <https://cutt.ly/FywmVcm> (last accessed Apr. 17, 2020); Connecticut State Dep't of Correction, Health Information and Advisories: Coronavirus Information, *available at* <https://cutt.ly/Jt3C5Mj> (last accessed Apr. 17, 2020); Connecticut State Dep't of Correction, Connecticut Correctional Facility Population Charts, <https://cutt.ly/VywmNif> (last accessed Apr. 17, 2020). Infection rate has been calculated as 100 x (number of cases/population).

44. As these numbers illustrate, immediate release of the Medically Vulnerable Subclasses remains a necessary public health intervention⁷⁹ because DOC's plan for preventative measures are insufficient to minimize the spread of the virus. For example, the DOC's plan permits recreation and programming to take place in groups of up to fifty incarcerated people, ten times the number of people permitted by the Governor's executive order.⁸⁰ Most importantly, the DOC's plan does not—and cannot—account for the physical infrastructure of DOC facilities, where thousands of people continue to live in dormitory or double-celled settings that house up to 140 people in a single building, sharing phones, showers, tables, toilets, bunk beds, and cells, with no ability to socially distance.

45. Similarly, the DOC's recent decision to transfer all COVID-19-positive incarcerated people to Northern is still insufficient to prevent the spread of coronavirus to the rest of the population in DOC facilities.⁸¹ Steven Wales, a correction officer at DOC facility Corrigan-Radgowski Correctional Center and union steward for Local 1565 of the American Federation of State, County and Municipal Employees, has stated that only incarcerated people who have tested positive are being moved; there are incarcerated people who are showing symptoms and are quarantined, but have not been tested yet.⁸² Mr. Wales still has concerns about the conditions at DOC facilities, and bluntly observed that the DOC has “a long way to go.”⁸³ Meanwhile, healthcare workers at DOC facilities have stated publicly that many aspects of DOC's handling of

⁷⁹ See Public Health Expert Declarations, *supra* notes 40–48.

⁸⁰ Compare Conn. Dep't of Correction, *COVID-19 Operational Response Plan 1* (Mar. 20, 2020), available at <https://cutt.ly/it3VtNr>, with Lamont Exec. Order 7N at 4.

⁸¹ State of Connecticut Dep't of Correction, *The Department of Correction transfers COVID-19 positive offenders to Northern CI* (Apr. 8, 2020), available at <https://cutt.ly/st3VuQ2>.

⁸² Siobhan McGirl, 'Stressful'; *CT Correction Officer Details Fight Against COVID-19 Inside Prison*, NBC CONN. (Apr. 8, 2020), <https://cutt.ly/wt3ViVl>.

⁸³ *Id.*

the pandemic—including moving incarcerated people frequently within facilities, and from facility to facility—has “blatantly go[ne] against what our medical advice was.”⁸⁴ Despite outbreaks at multiple low-level facilities, DOC has continued to transfer people from those facilities to other facilities, without testing for COVID-19 or attempting to trace exposure.

46. Transfers also do not eliminate the risk of the virus spreading in all other DOC facilities. Incarcerated people and staff members who are asymptomatic or pre-symptomatic can still infect others, especially while incarcerated people are unable to practice CDC-recommended social distancing and personal hygiene practices. While DOC officials wait for a positive test, which takes days, members of the Classes are quarantined in their cells or in medical facilities that do not comply with the CDC guidelines; therefore, fellow class members are still subject to infection. This continued risk is evidenced by the fact that the number of incarcerated people and DOC staff members testing positive continues to grow despite the transfer of most COVID-19-positive incarcerated people.⁸⁵

47. Further, the transfer of COVID-19-positive members of the Classes to Northern is only worsening the COVID-19 crisis in DOC facilities. Northern is the polar opposite of a hospital setting. Built in 1995 as Connecticut’s first and only supermax prison, Northern formerly housed incarcerated people on death row before the state abolished the death penalty. Since then, Northern has been used as a solitary confinement facility to “manage those inmates who have demonstrated

⁸⁴ Kelan Lyons, *Shifting Plans and a COVID-19 Outbreak at a Connecticut Prison*, CONN. MIRROR (Apr. 17, 2020), available at <https://ctmirror.org/2020/04/17/shifting-plans-and-a-covid-19-outbreak-at-a-connecticut-prison/>.

⁸⁵ On April 8, 2020, when the DOC started transferring COVID-19 positive incarcerated people, there were 46 incarcerated people and 52 staff members who tested positive. On April 20, those numbers grew to 293 COVID-19 positive incarcerated people and 202 COVID-19 positive staff members. See Connecticut State Dep’t of Correction, Health Information and Advisories: Coronavirus Information, available at <https://cutt.ly/jt3Vo2O> (last accessed Apr. 20, 2020).

a serious inability to adjust to confinement posing a threat to the safety and security of the community, staff, and other inmates.”⁸⁶ In August 2019, Chief Judge Stefan Underhill designated conditions of confinement for certain people held at Northern unconstitutional under the Eighth Amendment.⁸⁷

48. Northern’s conditions of confinement are singularly oppressive. Six units housing prisoners radiate outwards from a long, sloped, windowless corridor, meant to give the impression of walking underground. Light and sound reverberate off the concrete walls and mirrored windows, which are purposefully arranged at irregular angles to create a disorienting kaleidoscopic effect.

49. Each unit at Northern is identical in configuration, with two levels (“tiers”) on which cells are located. The cells at Northern are 7 feet by 12 feet.⁸⁸ They are made of concrete, and are designed to exacerbate Northern’s complete sensory deprivation. The only daylight and view outdoors comes through a narrow 4-inch by 3-inch slot at the back of each cell, which cannot be opened. The cell doors are solid steel, with a small “trap” through which Northern staff can shove food or cuff prisoners. While the cells have intercoms, they frequently do not work or are ignored.

50. Solitary confinement at Northern is not the same as the medical isolation recommended by the CDC. By placing COVID-19-positive incarcerated people in solitary confinement behind steel doors, Defendants-Respondents are punishing these individuals and

⁸⁶ Connecticut Dep’t of Corrections, Northern Correctional Institution, *available at* <https://cutt.ly/Ot3VazX> (last accessed on Apr. 17, 2020).

⁸⁷ *See Reynolds v. Arnone, et al.*, 402 F.Supp.3d 3 (D. Conn. 2019).

⁸⁸ *Id.* at 13.

depriving them of standard living conditions simply because they have fallen ill.⁸⁹ It also jeopardizes their wellbeing: quarantining people in a non-medical restrictive housing unit such as Northern “is particularly dangerous for those with COVID-19 infection since many patients with COVID-19 descend suddenly and rapidly into respiratory distress.”⁹⁰

51. Worse yet, fear of Northern is pervasive among the incarcerated population. Sending people to Northern simply because they test positive for COVID-19 is thus dangerous, as it deters others from reporting symptoms in an attempt to avoid the punitive conditions at Northern.⁹¹ As public health experts attest, “[t]his avoidance of reporting symptoms or illness will not only accelerate the spread of infection within facilities but also increase the likelihood of prisoner deaths due to lack of treatment.”⁹² This is especially so given that—notwithstanding its current use as the designated COVID-19-positive facility—DOC also continues to use Northern as a place for punishment. As recently as April 4, 19 incarcerated people at DOC’s Carl Robinson Correctional Institution were transferred to Northern as punishment for protesting DOC’s COVID-19 response.⁹³

52. DOC has stated that it has just one dedicated medical provider (APRN level or above) caring for the COVID-19 population at Northern, along with an unspecified number of

⁸⁹ Incarcerated people in solitary confinement are subjected to limited natural light, solid cell doors instead of barred walls, constraints on outside contact with family members, infrequent visits from security officers and medical staff, and frequent use of force. Prisoners in DOC’s general population are not subjected to these living conditions; therefore, the DOC is implementing punishment for incarcerated people that contract COVID-19. See David Cloud, et al., *The Ethical Use of Medical Isolation—Not Solitary Confinement—to Reduce COVID-19 Transmission in Correctional Settings* (Apr. 9, 2020).

⁹⁰ Williams Aff. ¶ 14.

⁹¹ David Cloud, et al., *supra* note 89; Rich Decl. ¶ 15.

⁹² David Cloud, et al., *supra* note 89.

⁹³ See Don Stacom, *Unrest at Enfield prison leads to fight Saturday afternoon; guard punched and 105 incarcerated people get transferred*, HARTFORD COURANT (Apr. 4, 2020), <https://cutt.ly/mt3VdFR>; Lisa Backus, *Fight erupts amid coronavirus tension at CT prison*, CT POST (Apr. 6, 2020), <https://cutt.ly/wt3Vf7f>.

nursing staff. As of April 20, that provider is responsible for 183 patients.

53. Finally, some of those who are being transferred to Northern are being returned to their original facilities after a few days—so long as they are not febrile—without being retested for COVID-19 and without any accompanying quarantining or sanitation measures.

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

54. Even in the best of times, DOC facilities, like many correctional settings, are beset with health problems and staffing challenges. Ominously, however, officials have exacerbated and increased the risks to the health and life of members of the Classes during the current pandemic by maintaining unconstitutional conditions of confinement that increase the risk of COVID-19 cases at DOC facilities.

55. Though everyone entering a Connecticut correctional facility is required to have a wellness screening, including a temperature check, recent data suggests that around 60% of COVID-19 cases are asymptomatic.⁹⁴ As a result, fevers are not a reliable indicator of whether someone is a carrier.⁹⁵ The prevalence of asymptomatic and pre-symptomatic COVID-19 carriers also belie Defendant-Respondent Governor Lamont’s claim that moving prisoners around inside the same sealed buildings will prevent the spread of infection.

56. Further, while DOC is transferring members of the Classes who test positive for COVID-19, there is a constant risk of transmission through DOC staff members. “Prisons and jails are not actually isolated from our communities: hundreds of thousands of correctional officers

⁹⁴ Jane Qiu, *Covert Coronavirus Infections Could Be Seeding New Outbreaks*, NATURE (Mar. 20, 2020), available at <https://cutt.ly/bt3VhFs>.

⁹⁵ Rich Decl. ¶ 9.

and correctional healthcare workers enter these facilities every day, returning to their families and to our communities at the end of their shifts, bringing back and forth to their families and neighbors and to incarcerated patients any exposures they have had during the day.”⁹⁶ As of April 20, 2020, 202 DOC staff members have tested positive for COVID-19.⁹⁷ DOC staff are further vectors of the virus: like incarcerated people, they may be asymptomatic but still contagious. This presents a daily risk of coronavirus infection in DOC facilities. Upon information and belief, DOC is taking staff members’ temperature upon their entrance to the facilities, but the high rates of asymptomatic transmission means that monitoring fever is inadequate to identify all who may be infected and thereby reduce the risk of transmission.⁹⁸ This also is true because not all individuals infected with COVID-19 present with fever in early stages of infection.⁹⁹

57. Similarly, DOC’s plan to transfer members of the Classes who have tested positive to Northern does not mitigate the risk of the infection spreading further in the DOC facilities. There are still incarcerated people at other DOC facilities who are showing symptoms, but have not yet been tested.¹⁰⁰ And given high rates of pre-symptomatic and asymptomatic transmission, it is impossible for DOC to transfer everyone to Northern quickly enough to prevent infection: once someone is symptomatic and/or tests positive, is it already too late. The exponential growth of COVID-19 among the DOC population between March 30 and April 20, with no sign of

⁹⁶ Williams Aff. ¶ 4; *see also* Rich Decl. ¶ 9.

⁹⁷ The DOC website reports that 202 staff members have tested positive for COVID-19 while 293 incarcerated people have tested positive. These staff members are employed in at least 13 different DOC facilities across Connecticut. *See* Connecticut State Dep’t of Correction: Health Information and Advisories, *available at* <https://cutt.ly/4t3VldA>.

⁹⁸ *See* State of Connecticut Dep’t of Correction, *First Department of Correction Employee to Test Positive of COVID-19 Virus* (Mar. 23, 2020), *available at* <https://cutt.ly/Ot3VzoN>; Rich Decl. ¶ 9.

⁹⁹ Rich Decl. ¶ 9 (“While entry temperature checks may be effective screening mechanisms for symptomatic infections, they are ineffective with [COVID-19] due to high rates of asymptomatic or pre-symptomatic infection.”).

¹⁰⁰ McGirl, *supra* note 82.

stopping, confirms that DOC's current approach is woefully insufficient to prevent the spread of the virus within the DOC facilities.

58. Meanwhile, class members in DOC facilities—aside from those transferred to Northern—continue to live in dormitory or double-celled settings, where they sleep, eat, bathe, and recreate within inches of tens or hundreds of others. Many continue to eat a foot apart. They continue to use dayrooms alongside hundreds of other people. They continue to share the same few phones. They continue to share toilets, sinks, and showers.

59. The sanitation practices inside DOC prisons continue to be lacking in light of the danger posed by COVID-19.¹⁰¹ Sanitation practices vary dramatically by facility, building, and unit. Class members in certain facilities do not have adequate access to soap. While some are being given credit card-sized bars of soap, others must purchase it through the commissary. No cleaning supplies are available for purchase in the commissary. Hand sanitizer is banned.

60. Some class members are given supplies with which to disinfect their cells once a week. Others are given none, and have attempted to clean their living quarters with bars of soap or shampoo. In certain facilities, class members are given one bottle of bleach to last a 100-person dormitory for a week. In others, class members are given only diluted bleach or diluted Lemonall. Common areas and showers are shared by tens or hundreds of people and are being cleaned only once a day. In certain facilities, handcuffs are used to move people out of cell. Handcuffs are not sanitized between uses.

61. When a class member tests positive for COVID-19 and is transferred, he is required to move his belongings to the facility's property unit. No cleaning is done of his personal space

¹⁰¹ Rich Decl. ¶ 10.

after he has been transferred. Those who live around the COVID-19-positive person are not provided any special cleaning supplies. Nor are they screened for COVID-19 symptoms. No consistent temperature screening has been performed in any facility, even those that have experienced significant outbreaks of COVID-19.

62. Class members in most DOC facilities were not given masks until April 1; others received them as late as April 10. The masks are made of a cloth material. They rip easily and are not replaced. When laundered, they develop mildew. Class members are punished if they attempt to fashion their own masks. They are not given gloves.

63. Some correctional officers wear masks or gloves, and others do not. As recently as the beginning of April, some medical staff were not wearing gloves to hand out medication. Correctional staff have continued to state that they do not have proper protective equipment.¹⁰² In certain facilities, correctional staff continue to “shake down” units by going through peoples’ personal belongings with their hands regularly.

64. Even when carriers are successfully identified and quarantined, additional space within a facility does not address the threat of potentially airborne diseases within sealed buildings,¹⁰³ which is only exacerbated by the poor ventilation in DOC facilities.¹⁰⁴

65. Defendants-Respondents also fail to adequately treat and quarantine individuals presenting with COVID-19 symptoms. Some members of the Classes have simply been locked in their cells for 14 days and not let out, even to shower or call relatives to say they are sick.

¹⁰² Kelan Lyons, *Shifting Plans and a COVID-19 Outbreak at a Connecticut Prison*, CONN. MIRROR (Apr. 17, 2020), available at <https://cutt.ly/BywQerQ>.

¹⁰³ See Rich Decl. ¶¶ 7, 8, 15.

¹⁰⁴ See also U.S. Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report, Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC* (July 7, 2006), available at <https://cutt.ly/Nt3Ve8L>.

Individuals report infrequent visits and temperature checks from healthcare staff. When someone tests positive, there is no screening of others with whom that person is housed—that is, there are no daily temperature checks or other attempts to monitor symptoms.

66. Finally, incarcerated people in Connecticut, like their counterparts nationwide, are given almost all of their medical treatment in the same facility in which they are housed, rather than in a dedicated medical facility such as a clinic or hospital. DOC has announced no special COVID-19 medical capabilities or staffing, other than the one dedicated provider at Northern. DOC's documented medical staffing shortages make it unlikely that any special or dedicated medical care is being provided.¹⁰⁵

67. Defendants-Respondents have failed to respond to and manage the continued risk of harm posed by the COVID-19 outbreak by following public health guidelines from the CDC.¹⁰⁶ To remedy these unsafe conditions and comply with CDC guidelines, Defendants-Respondents must implement a plan that allows DOC facilities to comply with CDC guidelines for social distancing, hygiene and sanitation practices, personal protective equipment ("PPE"), and adequate medical care.

68. Members of the Medically Vulnerable Subclasses are at an increased risk of developing serious complications from coronavirus infection and COVID-19 due to their underlying medical conditions.¹⁰⁷ Release is necessary not only to prevent irreparable harm to members of the Medically Vulnerable Subclasses, but also to reduce the incarcerated population

¹⁰⁵ Giftos Decl. ¶ 12.

¹⁰⁶ Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, <https://cutt.ly/et4kBga>.

¹⁰⁷ Rich Decl. ¶ 12.

at all DOC facilities enough to ensure proper social distancing, which will reduce the likelihood of infection for the Classes, staff at the DOC facilities, and the broader public.¹⁰⁸

69. In short, even if those who have tested positive are transferred to a separate facility, it is unrealistic to assume that “screening, social distancing, and quarantining measures can be sufficiently employed with correctional settings to combat the spread of COVID-19,”¹⁰⁹ because “[t]here are too many structural limitations, and correctional health care can only do so much.”¹¹⁰ “Decreasing the incarcerated population so there is more ability to physically distance within the facility, fewer people who can contract the virus inside the facility, and more medical care for those who need it is the only way to prevent the complications from surging.”¹¹¹

IV. CLASS ACTION ALLEGATIONS

70. Plaintiffs McPherson, Williams-Void, Doe, Roe, and Caves bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of themselves and a class of similarly situated individuals.

71. Plaintiffs McPherson and Williams-Void seek to represent a class of all people held in pretrial custody, including for alleged violations of probation or parole, at DOC facilities (“Pre-adjudication Class”). The Pre-adjudication Class includes a subclass of all persons who, by reason of age or medical condition, are particularly vulnerable to injury or death from COVID-19

¹⁰⁸ *Id.* ¶¶ 16, 17 (“[U]rgent decarceration is imperative to flatten the curve of Covid-19 cases among incarcerated populations and to limit the impact of transmission both inside correctional facilities and in the community.”). Further, in the prison context, the American Bar Association (ABA) urges that, “Governmental authorities in all branches in a jurisdiction should take necessary steps to avoid crowding that... adversely affects the ... protection of prisoners from harm, including the spread of disease.” ABA Standard on Treatment of Prisoners 23-3.1(b).

¹⁰⁹ *Giftos Aff.* ¶ 25.

¹¹⁰ *Id.* ¶ 26.

¹¹¹ *Id.*

(“Medically Vulnerable Pre-adjudication Subclass”). Plaintiff Williams-Void is a representative and member of the Medically Vulnerable Pre-adjudication Subclass.

72. Plaintiffs Doe, Roe, and Caves seek to represent a class of all people held in post-adjudication custody in a DOC facility, including those serving a term of incarceration pursuant to an adjudicated violation of probation or parole, at DOC facilities (“Post-adjudication Class”). The Post-adjudication Class includes a subclass of persons who, by reason of age or medical condition, are particularly vulnerable to injury or death from COVID-19 (“Medically Vulnerable Post-adjudication Subclass”). Plaintiffs Doe and Roe also are representatives and members of the Medically Vulnerable Post-adjudication Subclass.

73. The Medically Vulnerable Subclasses include all people 50 or older who are in custody at DOC facilities and all people in custody at DOC facilities who have been diagnosed with: (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g., bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure, and coronary artery disease; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy.

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

75. Joinder is impracticable because (1) the classes are numerous; (2) the classes include unidentifiable future members; and (3) the class members are incarcerated, which limits their ability to file and pursue individual lawsuits, particularly in light of the cessation of legal visitation and court closures in the state of Connecticut.

76. On information and belief, there are at least 11,840 people in the proposed Classes. The information as to the exact size of the Classes and Subclasses and the identity of the individuals therein are in the exclusive control of the Defendants-Respondents.

77. Common questions of law and fact exist as to all members of the proposed Classes: all have the right to conditions of confinement that do not put them at increased risk of infection and complications from COVID-19.

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

79. Plaintiffs McPherson, Williams-Void, Doe, Roe, and Caves have the requisite personal interest in the outcome of this action and will fairly and adequately protect the interests of the class. They have no interests adverse to the interests of the proposed Classes. They retained *pro bono* counsel with experience and success in the prosecution of civil rights litigation. Counsel for Plaintiffs know of no conflicts among members of the Classes or between counsel and members of the Classes.

80. Defendants-Respondents have acted on grounds generally applicable to all members of the Classes, and this action seeks declaratory and injunctive relief. Plaintiffs therefore

seek class certification under Rule 23(b)(2).

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

V. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

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

42 U.S.C. § 1983/28 U.S.C. § 2241

Pre-adjudication Class versus All Defendants

82. The Fourteenth Amendment provides greater due process protections to persons in pretrial custody, and prohibits punishment as part of their detention. *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979). A defendant has punished plaintiffs when the conduct is either not rationally related to a legitimate, non-punitive governmental purpose or excessive in relation to that purpose.

83. Even assuming that Defendants-Respondents' spacing and provision of medical services inside DOC facilities normally serve the legitimate, non-punitive purpose of health and safety of detained persons, the current operation of the DOC facilities during this pandemic establishes that Defendants-Respondents are unable to sufficiently comply with public health guidelines to prevent an outbreak of COVID-19. Therefore, continuing to detain members of the Pre-adjudication Class under conditions of confinement that are inconsistent with COVID-19-specific guidance from public health experts is not rationally related to, and excessive in relation to, that purpose.

84. Accordingly, Defendants-Respondents have violated the rights of the Pre-adjudication Class under the Fourteenth Amendment.

SECOND CLAIM FOR RELIEF

**Unconstitutional Confinement in Violation of the
Fourteenth Amendment to the U.S. Constitution**
42 U.S.C. § 1983/28 U.S.C. § 2241
Pre-adjudication Class versus All Defendants

85. Under the Fourteenth Amendment, corrections officials are required to provide for the reasonable health and safety of persons in pretrial custody. *Youngberg v. Romeo*, 457 U.S. 307, 315–16, 324 (1982). Correctional officials thus have an affirmative obligation to protect persons in their custody from infectious disease. The protection due to detainees under the Fourteenth Amendment is even greater than the protection due to those incarcerated after adjudication, because pretrial detainees are “entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.” *Youngberg*, 457 U.S. at 321–22. Thus, the “Fourteenth Amendment affords pretrial detainees protections ‘at least as great as the Eighth Amendment protections available to a convicted prisoner.’” *Id.* (quoting *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983)).

86. The DOC has failed to comply with public health guidelines to manage an outbreak of COVID-19 and has not provided for the safety of the Pre-adjudication Class. Defendants-Respondents’ actions and inactions result in the confinement of members of the Pre-adjudication Class in facilities where they do not adequately test for, treat, or prevent COVID-19 outbreaks, which violates Plaintiffs’ rights to treatment and adequate medical care.

87. Accordingly, Defendants-Respondents have violated the rights of the Pre-Adjudication Class under the Fourteenth Amendment.

THIRD CLAIM FOR RELIEF
Unconstitutional Conditions of Confinement in Violation
of the Eighth Amendment to the U.S. Constitution
42 U.S.C. § 1983/28 U.S.C. § 2241
Post-adjudication Class versus All Defendants-Respondents

88. Officials violate incarcerated individuals’ rights when they are deliberately indifferent to conditions of confinement that are likely to cause them serious illness and that pose an unreasonable risk of serious damage to their future health. *Helling v. McKinney*, 509 U.S. 25, 33–34 (1993). The Supreme Court held in *Helling v. McKinney* that the government violates the Eighth Amendment when it crowds prisoners into cells with others who have “infectious maladies” or otherwise exposes prisoners “to a serious, communicable disease.” 509 U.S. 25, 33 (1993) (citing *Hutto v. Finney*, 437 U.S. 678, 682 (1978)). This is true “even though the possible infection might not affect all of those exposed.” *Id.*

89. DOC facilities, as currently operated, are unable to comply with public health guidelines to prevent an outbreak of COVID-19, and Defendants-Respondents have not and cannot provide for the safety of the Post-adjudication Class. This remains true despite DOC’s recent transfer of COVID-19-positive incarcerated people to a separate facility, because Defendants-Respondents have not taken appropriate steps to test for, treat, and prevent further COVID-19 outbreaks, and Defendants-Respondents are unable to protect the Medically Vulnerable Post-adjudication Subclass from serious harm caused by COVID-19, in violation of their constitutional obligation to provide humane conditions of confinement.

90. Accordingly, Defendants-Respondents have violated the rights of the Post-adjudication Class under the Eighth Amendment.

VI. REQUEST FOR RELIEF

91. Plaintiffs McPherson, Williams-Void, Doe, Roe, Caves, and Class Members respectfully request that the Court order the following:

1. Certification of this Petition as a Class Action.
2. A preliminary injunction, permanent injunction, and/or writs of habeas corpus requiring Defendants-Respondents to identify all Medically Vulnerable Subclass Members in both the Pre-adjudication and Post-adjudication Classes within six (6) hours of the Court's order and release—within twenty-four (24) hours of submission of the list—all such persons absent proof of judicially-recorded findings by clear and convincing evidence that the individual poses such a serious risk of flight or danger to others that no other conditions can mitigate; and ordering that Defendants-Respondents provide these individuals with educational resources on COVID-19, including instructions that they should self-isolate for the CDC-recommended period of time (currently 14 days) following release.
3. Following immediate release of all Medically Vulnerable Subclass Members, a plan, to be submitted to the Court in three (3) days and overseen by a qualified public health expert agreed upon by the parties or ordered by the Court pursuant to Fed. R. Evid. 706, which outlines:
 - a. Specific mitigation efforts, consistent with CDC guidelines, to significantly reduce the risk of COVID-19 for all class members who remain in DOC custody; and
 - b. An evaluation of whether release of the members of the Medically Vulnerable Subclasses permits social distancing by those who remain in DOC custody, or whether DOC must release additional members of the Classes to be in compliance with CDC guidelines.
4. A preliminary injunction, permanent injunction, and/or writ of habeas corpus requiring Defendants-Respondents to:
 - a. Continue to release via habeas or transfers to home confinement, all Medically

Vulnerable Subclass members absent proof of judicially-recorded findings by clear and convincing evidence that the individual poses such a serious risk of flight or danger to others that no other conditions can mitigate;

- b. Report weekly on the population of persons in DOC facilities who are Medically Vulnerable as defined in this action;
 - c. Follow the terms of the public health expert plan submitted pursuant to Fed. R. Evid. 706;
 - d. Release via habeas, or transfer to home confinement, additional members of the Classes, including those not considered “Medically Vulnerable,” as needed to ensure that all remaining persons incarcerated in DOC facilities are under conditions consistent with CDC and public health guidance to prevent the spread of COVID-19.¹¹²
5. If immediate release is not granted on the basis of this Petition alone, then expedited review of the Petition, including an evidentiary hearing and/or oral argument, via telephonic or videoconference if necessary.
6. A declaration that Defendants-Respondents’ policies and actions have created unconstitutional conditions of confinement and punishment that violate the Eighth and Fourteenth Amendments.
7. An award of Plaintiffs’ attorney fees and costs under 42 U.S.C. § 1988, 42 U.S.C. § 12205, and other applicable law.

¹¹² If, after granting habeas writs and/or transfer orders to home confinement as outlined above, additional release orders are required to comply with the public health expert plan submitted pursuant to Fed. R. Evid. 706, Plaintiffs would anticipate moving the Court to convene a three-judge panel pursuant to 18 U.S.C. § 326(a)(3).

8. Any further relief this Court deems just and appropriate.

Respectfully submitted,

Dan Barrett (# ct29816)
Elana Bildner (# ct30379)
ACLU Foundation of Connecticut
765 Asylum Avenue
Hartford, CT 06105
(860) 471-8471
e-filings@acluct.org

Will W. Sachse, Esq.*

Dechert LLP

Cira Centre
2929 Arch Street
Philadelphia, PA 19104-2808
T: (215) 994-2496
F: (215) 665-2496
will.sachse@dechert.com

Jenna C. Newmark*

Gabrielle N. Piper*

Dechert LLP

Three Bryant Park
1095 Avenue of the Americas
New York, NY 10036
T: (212) 649-8723
F: (212) 314-0064
jenna.newmark@dechert.com
gabrielle.piper@dechert.com

Jonathan Tam*

Dechert LLP

One Bush Street, Suite 1600
San Francisco, CA 94104-4446
T: (415) 262-4518
F: (415) 262-4555
jonathan.tam@dechert.com

Brandon Buskey*

American Civil Liberties Foundation

125 Broad Street, 18th Floor
New York, NY 10004
(212) 284-7364
bbuskey@aclu.org

**pro hac vice to be submitted*

Attorneys for Plaintiffs-Petitioners

EXHIBIT A

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.
2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of April 2, 2020, there are over 800,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 45,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States in regions like New York, New Jersey, Louisiana, Michigan and Illinois.
3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.
4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

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

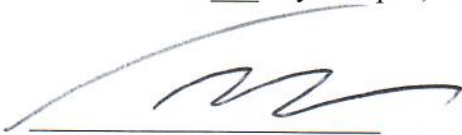
5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.
6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.
7. When a community or institution lacks a comprehensive and rigorous testing regime, a lack of proven cases of COVID-19 is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.
8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.
9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called 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.

10. There is no cure and vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.
11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.
12. In early March, the highest known person-to-person transmission rates for COVID-19 were in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. More recently, the highest transmission rates have been recorded in the Rikers Island jail complex in New York City, which is over seven times the rate of transmission compared to the spread in New York City. To illustrate, the number of confirmed cases among inmates soared from one to nearly 200 in the matter of 12 days.
13. This is consistent with the spread of previous viruses in congregate settings. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.
14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to

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

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

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

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

Dr. Jonathan Louis Golob

Jonathan Louis Golob, M.D. Ph.D.

Assistant Professor

206 992-0428 (c) 734-647-3870 (o)

golobj@med.umich.edu jonathan@golob.org

Education and Training

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

Certifications and Licensure

Board Certifications

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

Current Medical Licenses to Practice

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

Academic, Administrative, and Clinical Appointments

Academic

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

Clinical

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

Research Interests

1. I am primarily interested in understanding how the human gut microbiome *mechanistically* affects how patients respond to treatments. I have a particular focus on patients undergoing hematopoietic cell transplant, who are at risk for recurrence of their underlying disease, treatment-related colitis (from both conditioning and graft versus host disease), and infection. In human observational trials the human gut microbiome correlates with each of these aspects. My research program uses advanced stem-cell based *in-vitro* models of the human colonic mucosa to verify if the correlations in observational trials can cause similar effects *in vitro*, and then determine by which pathways (e.g. receptors) and broad mechanisms (e.g. epigenetics) the microbes affect the host.
2. Host-microbiome interactions are contextual. A beneficial interaction in health can turn pathologic. For example, my ongoing work focused on the microbial metabolite butyrate. Butyrate enhances the health of healthy and intact colonic epithelium, acting as a substrate for cellular respiration and through receptor-mediate processes reduces cellular inflammation. However, butyrate also blocks the ability of colonic stem cells to differentiate into mature epithelium. Thus, in colitis that results in a loss of colonic crypts, an intact and butyrogenic gut microbiome results in colonic stem cells being exposed to butyrate and inhibits recovery. My ongoing work uses a primary stem-cell based model of the human colonic mucosa to establish how butyrate blocks the differentiation of colonic stem cell with a hope of generating new treatments for patients with steroid-refractory colitis.
3. I am interested in validating and improving computational tools for biological research. I have a computer science and biomedical engineering background that combined with my clinical and molecular biology training positions me optimally to understand both major aspects of computational biology: what are the needs to make biological inferences from big data, and how can tools specifically be improved to achieve such inferences.

Grants*Present and Active***ASBMT New Investigator Award** J. Golob (PI) 7/2018 – 7/2020

Hematopoietic Cell Transplant Outcomes and Microbial Metabolism

Role: PI

\$30,000/yr for up to two years

NIH / NIAID R01

D. Fredricks (PI)

11/2017 – 11/2021

The Gut Microbiota and Graft versus Host Disease (GVHD), AI-134808

Role: Senior / key personnel

\$823,701

NIH P01

T. Schmidt (PI)

Pending / Reviewed

ENGINEERING MICROBIOMES AND THEIR MOLECULAR DETERMINANTS FOR PRODUCTION OF BUTYRATE AND SECONDARY BILE ACIDS FROM RESISTANT STARCH

Role: Key Personnel

NIH / NCI R21

J. Golob (PI)

Pending / Submitted

Establishing a physiologic human colonic stem/progenitor cells model of regimen-related colitis

Role: PI

NIH R21

J. Golob (PI)

Pending / Submitted

Manipulating Butyrate Production by the Gut Microbiome during Chronic HIV Infection

Role: PI

*Completed***Joel Meyers Endowment Fellowship**

6/2016 – 6/2018

Role: Research Fellow

\$63,180

DCDR Grant

R. Harrington (PI)

6/2014 – 6/2018

Support for data queries into the Deidentified Clinical Data Repository

Role: PI

\$1000

NIH T32 Institutional Training Grant

M. Boeckh (PI)

8/2016 – 8/2017

1T32AI118690-01A1

Role: Post-Doc Trainee

\$315,972

NIH T32 Institutional Training Grant

W. van Voorhis (PI)

7/1/14 – 6/30/16

5T32AI007044

Role: Post-Doc Trainee

\$1,527,801

Honors and Awards

2001 Tau Beta Pi Engineering Honor Society

2001 Alpha Eta Mu Beta Biomedical Engineering Honor Society

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

Membership in Professional Societies

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

Bibliography

Peer-Reviewed Journals and Publications

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

- Transplant Recipients. *Biol Blood Marrow Transplant*. 2018 May 16. pii: S1083-8791(18)30268-4. doi: 10.1016/j.bbmt.2018.05.016. [Epub ahead of print]
12. **Golob JL**, Stern J, Holte S, Kitahata MM, Crane HM, Coombs RW, Goecker E, Woolfrey AE, Harrington RD. HIV DNA levels and decay in a cohort of 111 long-term virally suppressed patients. *AIDS*. 2018 Sep 24;32(15):2113-2118. doi: 10.1097/QAD.0000000000001948.
 13. **Golob JL**, DeMeules MM, Loeffelholz T, Quinn ZZ, Dame MK, Silvestri SS, Wu MC, Schmidt TM, Fiedler TL, Hoostal MJ, Mielcarek M, Spence J, Pergam SA, Fredricks DN. Butyrogenic bacteria after acute graft-versus-host disease (GVHD) are associated with the development of steroid-refractory GVHD. *Blood Adv*. 2019 Oct 8;3(19):2866–2869.

Preprint publications

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

Other Publications

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

Abstracts (presenter underlined)

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

Invited Lectures

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

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

EXHIBIT B

Declaration of Dr. Jonathan Giftos

I, Jonathan Giftos, declare as follows:

1. I am a doctor duly licensed to practice medicine in the State of New York. I am board-certified in internal medicine and addiction medicine. I received my Bachelor of Science degree from Boston College, and my Medical Degree from Mount Sinai School of Medicine.
2. I am currently the Medical Director, Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine.
3. Between August 2016 and January 2020, I was an Attending Physician and the Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island. During this time, I provided primary medical care to detainees and sentenced patients, and supervised the nation's oldest and largest jail-based opioid treatment program. I successfully led an effort to remove non-clinical barriers to opioid treatment program enrollment in 2017, which dramatically expanded treatment access from 25% to over 80%, while also reducing post-release mortality for people with opioid use disorder.
4. I have extensive experience working with vulnerable populations such as the incarcerated and those experiencing homelessness.
5. In the course of my duties as Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island, I entered every facility in the New York City Department of Correction. I have firsthand knowledge of the various housing types—from dormitory housing to single-cell units—in correctional facilities.

The Coronavirus Pandemic

6. On March 11, 2020, the World Health Organization declared that the rapidly spreading outbreak of COVID-19, a respiratory illness caused by a novel coronavirus, is a pandemic, announcing that the virus is both highly contagious and deadly. To date, the virus is known to spread from person-to-person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects. The CDC also warns of “community spread” where the virus spreads easily and sustainably within a community where the source of the infection is unknown.
7. There is currently no vaccine or cure. The primary focus is on preventing the spread of the virus at this juncture. To prevent new infections, the Centers for Disease Control and Prevention strongly recommend the following actions: thorough and frequent handwashing, cleaning surfaces with EPA-approved disinfectants, keeping at least six

feet of space between people, and avoiding group settings. Social distancing has also been encouraged to slow the rate of COVID-19 infections so that hospitals have the resources to address infected individuals with urgent medical needs. In correctional settings, such sanitation, social distancing, and self-quarantining measures are nearly impossible.

8. Experts continue to learn more about the transmission of novel coronavirus. Recent evidence has aided scientists and healthcare professionals in understanding why COVID-19 spreads so rapidly and dangerously. While it is well-known that symptomatic people transmit the virus, two additional transmission categories are essential to understanding the alarming rate of infection linked with the novel coronavirus: (1) asymptomatic transmission, or people who are infected and contagious but never display the symptoms associated with COVID-19, and (2) presymptomatic transmission, or people who are contagious *before* they begin to show symptoms.
9. On April 1, 2020, the CDC published a critically important study finding evidence of presymptomatic transmission.¹ In it, the CDC warned that “[t]he potential for presymptomatic transmission underscores **the importance of social distancing, including the avoidance of congregate settings**, to reduce COVID-19 spread” (emphasis added).²
10. Given what we now know about how the novel coronavirus spreads and how often transmission occurs when an infected person is not displaying any symptoms whatsoever, even robust efforts to screen symptoms and isolate presumed positives are *not enough to prevent transmission*. Any system that relies on such a screening model will not stop the spread of the virus. From what we have learned, a combination of genuine and strict social distancing, handwashing, sanitation, and widespread testing and contact tracing are the measures effective to protect populations from rapid infection.
11. The Centers for Disease Control have identified two groups of people at higher risk of contracting and succumbing to COVID-19: adults over 60 years old and people with chronic medical conditions. COVID-19 is more dangerous to persons in these high-risk groups than to the general population. Older people who contract COVID-19 are more likely to die than people under the age of 60. It has been found that older people diagnosed with COVID-19 are more likely to be very sick and require hospitalization to survive because the acute symptoms include respiratory distress, cardiac injury, arrhythmia, septic shock, liver dysfunction, kidney injury and multi-organ failure. Access to a mechanical ventilator is often required. People with chronic medical conditions (no matter their age) are also at significantly greater risk from COVID-19 because their already-weakened systems are less able to fight the virus. These chronic medical conditions include lung disease, cancer, heart failure, cerebrovascular disease, renal

¹ Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020. *MMWR. Morbidity and Mortality Weekly Reports*, at <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6914-H.pdf>.

² *Id.*, p.412.

disease, liver disease, diabetes, immunocompromising conditions, and pregnancy. Those with pre-existing medical conditions have a higher probability of death if infected.

COVID-19 Within Correctional Settings

12. Based on my years of providing medical care at Rikers Island, I know that correctional settings increase the risk of contracting an infectious disease like COVID-19. This is because there are high numbers of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others.
13. Correctional facilities house large groups of inmates together, and move inmates in groups to eat, bathe, and recreate. They frequently have insufficient medical care for the population, and, in times of crisis, even those medical staff cease coming to the facility. Hot water, soap, disinfectants, and paper towels are frequently in limited supply, and inmates, rather than professional cleaners, are responsible for cleaning the facilities. As a result, there are more people susceptible to getting infected congregated together in a context in which fighting the spread of an infection is nearly impossible.
14. Indeed, outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases. In the current outbreak, Rikers Island went from just one confirmed case of COVID-19 on March 18 to 231 confirmed cases in just two weeks.³

COVID-19 and the Physical Infrastructure of Prison

15. I understand that Connecticut correctional settings are a mix of dormitory settings and single-cell settings. Both settings pose significant challenges to the ability of staff and incarcerated people alike to abide by CDC guidelines.
16. Dorm housing areas are particular breeding grounds for COVID-19. Beds in these units are typically in one room, and far less than six feet apart. People housed in dorms must share common sinks, toilets, showers, phones, tables and chairs.
17. Adequately sanitizing a space with those characteristics would require constant diligence and a continuous abundance of cleaning supplies. Cleaning once a day, or even a few times a day, would not prevent transmission of the virus. Social distancing, even at significantly reduced capacity, is virtually impossible due to the physical realities of the shared spaces in the dorms and the difficulty of adequately sanitizing a space inhabited by a constantly rotating population of incarcerated people and staff.

³ *Compare As Testing Expands, Confirmed Cases of Coronavirus in N.Y.C. Near 2,000*, N.Y. Times (Mar. 18, 2020), <https://www.nytimes.com/2020/03/18/nyregion/coronavirus-new-york-update.html> (first positive case at Rikers) with The Legal Aid Society, *Covid-19 Tracking in NYC Jails*, Apr. 2, 2020, <https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails> (231 cases today).

18. Single-cell housing areas also pose elevated risk of transmitting the virus. Though single cell units are typically equipped with a toilet and sink, incarcerated people must leave the cell for many reasons: to use a shared shower, or to go to the clinic, or potentially to use a shared phone or perform a job. Meals are still prepared and delivered from other parts of the jail. Incarcerated people housed in single cells are also subject to exposure from the myriad operational characteristics endemic in the jail setting, described below. All of these factors demonstrate the difficulty of effective social distancing and sanitation even in more isolated single-cell units.

COVID-19 and the Operational Characteristics of Prison

19. My experience in correctional health also exposed me to the limitations of correctional health care. Similar to an outpatient primary care clinic, correctional health care is designed to provide urgent care for ailments that are non-life threatening. It is not capable of providing the type of care one receives in a hospital, let alone in an intensive care unit. As a result, when an incarcerated person requires hospitalization or intensive care, they are transferred to a hospital in the community. During my time at Rikers Island, we routinely transferred incarcerated people to community hospitals to receive care that we could not provide at the facility.
20. For prison systems that are already understaffed, staffing shortages will only increase as employees need to stay home to care for children whose schools are closed, elderly family members, and—if infected or exposed to infection—themselves. With fewer staff, correctional officers are even less able to monitor prisoners' health.
21. During the COVID-19 pandemic, these limitations in correctional health care have important public health implications not just for incarcerated populations, but for the general population as well. According to the most recent estimates, at least 15% of people who contract COVID19 will require hospitalization, and 5% will require intensive care. Based on the vulnerability of the incarcerated population, it is likely that these numbers would be at least as high, if not higher, within a correctional setting.
22. A person who contracts COVID-19 in jail or prison and requires hospitalization will need to be transferred to a community hospital. As a result, the problem of a prison outbreak of COVID-19 infections cannot and will not be contained within the institution itself. Instead, it will explode into the community, increasing the pressure on our already taxed community hospitals.
23. Even at baseline, ICU beds and ventilators in our community hospitals are a scarce commodity. A recent analysis by the Harvard Global Health Institute indicates that under most scenarios, "vast communities in America are not prepared to take care of the COVID-19 patients" that require hospital care. An outbreak of COVID-19 at a jail or prison, which would likely require numerous transfers to a community hospital, could push a hospital even further past its breaking point. Specifically, a surge in COVID-19

infections in a correctional setting could mean that ICU beds in the community hospital would no longer be available to everyone who needed them.

24. A final characteristic of prison that must be considered in the instant health crisis is the inevitable operational gaps in a system of Connecticut's size and the risks that those gaps pose to staff and people in custody. DOC's filings contain descriptions of policies that would certainly play a critical role in reducing the harm from the COVID-19 pandemic: frequent and thorough cleaning and sanitizing regimens, ongoing health education, and adequate provision of soap, sinks, and cleaning supplies. In order to be effective, of course, policies must be implemented with fidelity and require adequate staffing levels to do so. In my time in correctional health, I witnessed many instances in which execution of policies relating to sanitation, provision of basic items, and other requirements fell short. When staffing levels are short and the numbers of those infected continue to rise, I remain gravely concerned that people in custody do not have the supplies and environmental controls necessary to protect them and staff from the pandemic, notwithstanding effort to create policies to address this problem.

Correctional Settings Cannot Be Equipped to Keep People Safe from COVID-19

25. Every effort should be made to reduce chances of exposure to COVID-19. However, based on my experience in correctional health, I do not believe that screening, social distancing, and quarantining measures can be sufficiently employed within correctional settings to combat the spread of COVID-19.
26. Correctional settings simply cannot be equipped to keep people safe during this pandemic. There are too many structural limitations, and correctional health care can only do so much. Decreasing the incarcerated population so that there is more ability to physically distance within the facility, fewer people who can contract the virus inside the facility, and more medical care for those who need it is the only way to prevent the complications from surging. Otherwise, the unchecked transmission of COVID-19 in jail or prison will have serious, and fatal, implications for the broader community.
27. Decreasing the incarcerated population will also decrease the necessary staffing for the facility and protect staff from exposure. Reducing the number of needed correctional officers and healthcare workers will, in turn, reduce the number of people entering and exiting the facility on a daily basis. This too will reduce the spread of COVID-19 to the broader community.
28. It is my professional opinion that these steps are both necessary and urgent, and that reducing population via standard, one-by-one mechanisms will fall far short of what is required to prevent a public health crisis. The infection rate inside Rikers is now eight times higher than the infection rate in New York City. I understand that Connecticut has gone from one incarcerated person testing positive to 182 positive tests in two weeks, along with 118 staff. These surging numbers mean that, without immediate action, Connecticut will likely follow the same trajectory.

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

Executed on April 17, 2020 in **New York, New York**.

A handwritten signature in black ink, appearing to read "J. Giftos", is positioned above a horizontal line.

Jonathan Giftos, M.D.

EXHIBIT C

Declaration of Dr. Josiah Rich, M.D., MPH

1. I am a doctor duly licensed to practice medicine in the state of Rhode Island.
2. I am currently Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital.
3. I have been a practicing Infectious Disease Specialist since 1994. I provide clinical care at The Miriam Hospital Immunology Center, as well as at the Rhode Island Department of Corrections, where I care for prisoners with HIV infection and work in the correctional setting doing research.
4. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I am an elected member of the National Academy of Medicine and I have served as an expert for the National Academy of Sciences, the Institute of Medicine, and many others. I have also been appointed by Rhode Island Governor Gina Raimondo to the Overdose Prevention and Intervention Task Force Expert Team. I have published close to 190 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions, and incarceration.
5. The matters that I discuss below are proceeding at a rapid pace across the country. I have published about these urgent concerns in the New England Journal of Medicine, the Washington Post, and elsewhere. I attach copies of those articles to this affidavit.

The extreme challenges Covid-19 poses for Connecticut's prison system.

6. As we are quickly seeing throughout the United States and the world, highly transmissible novel respiratory pathogens such as SARS-CoV-2—the virus that causes Covid-19—create a perfect storm for correctional settings.

7. First, correctional settings are ideal for rapid spread of viruses that are transmitted person-to-person, especially those passed by droplets through coughing and sneezing. When people must share dayrooms, bathrooms, showers, and other common areas, the opportunities for transmission are great. And while there continues to be disagreement about whether SARS-CoV-2 is an airborne virus, in the context of limited information, we must assume that it is. In that case, the poor ventilation systems within correctional facilities will ensure maximal opportunities for transmission.

8. When viruses are transmitted from person to person, the best initial strategy is to practice social distancing. Yet social distancing is extremely challenging in correctional settings. Even when facilities are locked down and use of common space are limited, there is inevitably frequent contact among prisoners, and especially between prisoners and staff. Even a quick cell change or shower involves multiple opportunities for contact with others. Accordingly, no matter what measures we take, correctional facilities are congregate settings that are poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

9. I understand that Connecticut, like other systems, has suspended visitation and facility transfers, and has taken certain other measures to try to limit infection. Irrespective of these interventions, however, infected persons—especially staff members—will inevitably continue to enter correctional settings. It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. Rather, the boundaries between

correctional institutions and the communities in which they sit are extremely porous. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, population turnover means that people cycle between facilities and communities. And people often need to be transported to and from facilities, including for disciplinary and/or quarantining purposes. All of this is problematic in the context of this pandemic: While entry temperature checks may be effective screening mechanisms for symptomatic infections, they are ineffective with SARS-CoV-2 due to high rates of asymptomatic or pre-symptomatic infection.

10. Moreover, there are reduced prevention opportunities in prisons. During an infectious disease outbreak, free people can protect themselves by washing hands. Correctional facilities do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. These facilities are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for both 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 bleach is often unavailable, and cleaning agents used by correctional settings may not have been shown to effectively neutralize this virus, particularly in the diluted form commonly employed. There may also be a lack of people available to perform necessary cleaning procedures, which is exacerbated as people fall ill and movement is restricted.

11. A containment strategy for this virus requires both widespread screening and that people who are symptomatic be immediately isolated. It also requires that correctional officers and caregivers have access to personal protective equipment, including gloves, masks, gowns, and face shields. Yet correctional settings 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 where an outbreak is occurring. Correctional settings are also unlikely to be able to perform the widespread screening and contact-tracing necessary to prevent further infection.

12. All of the above is compounded by the fact that half of all incarcerated people in the United States have at least one chronic disease. With limited ability to protect themselves and others by self-isolating, thousands of susceptible people are at heightened risk for severe illness.

Lessening the spread of Covid-19 requires urgent, scaled-up decarceration.

13. The more preemptive measures taken by legal, public health, and correctional health partnerships, the lighter the burden the correctional facilities and their surrounding communities will bear. The global context offers some precedent here. Iran, for example, responded to its escalating pandemic by releasing 70,000 prisoners, something that may have helped “bend the curve” of that country’s epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons.

14. At minimum, Connecticut must be prepared to isolate and separate incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; to hospitalize those who are seriously ill; and to cope with the high burden of disease and severe staff shortages that are likely to come.

15. But this won’t be enough. I understand that as of April 15, 2020, there were 199 confirmed positive COVID-19 cases among incarcerated people in Connecticut, and 139 confirmed positive cases among DOC staff. I also understand that Connecticut is transitioning people who test positive to the state’s maximum security prison. This raises the concern that

incarcerated people will be deterred from reporting symptoms of COVID-19 or seeking medical attention. It is also not clear to me how a maximum security prison is positioned to provide the level of medical care and observation that COVID-19 patients may require, including a low provider-to-patient ratio and specialized medical equipment. While the initial presentation of COVID-19 may seem mild, I have seen from firsthand experience that patients can decompensate rapidly, requiring intubation and ICU-level care in a matter of hours. Finally, while current guidelines by the CDC recommend that patients be quarantined for 14 days or 72 hours without symptoms, whichever is longer, we know that some patients continue to shed the virus for as long as 30 days.

16. As shown by the drastic surge in COVID-19 positive cases within DOC in a very short period of time, it is imperative to scale up efforts to “decarcerate,” or release, as many people as possible, including those detained on bail. Each person needlessly infected in a correctional setting who develops severe illness will be one too many. And public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in correctional facilities during a pandemic.

17. It is my strong opinion that urgent decarceration is imperative to flatten the curve of Covid-19 cases among incarcerated populations and to limit the impact of transmission both inside correctional facilities and in the community. The abrupt onset of severe Covid-19 infections among incarcerated individuals will require mass transfers to local hospitals for intensive medical and ventilator care—highly expensive interventions are already in very short supply. Each severely ill patient coming from the Department of Correction who occupies an ICU bed may mean others may die for inability to obtain care. These are preventable infections, and we should act to prevent them.

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

Executed on April ____, 2020 in _____.

Dr. Josiah Rich



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Flattening the Curve for Incarcerated Populations — Covid-19 in Jails and Prisons

Matthew J. Akiyama, M.D., Anne C. Spaulding, M.D., and Josiah D. Rich, M.D.

Because of policies of mass incarceration over the past four decades, the United States has incarcerated more people than any other country on Earth. As of the end of 2016, there were

nearly 2.2 million people in U.S. prisons and jails.¹ People entering jails are among the most vulnerable in our society, and during incarceration, that vulnerability is exacerbated by restricted movement, confined spaces, and limited medical care. People caught up in the U.S. justice system have already been affected by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and improved preparation is essential to minimizing the impact of this pandemic on incarcerated persons, correctional staff, and surrounding communities.

Populations involved with the criminal justice system have an increased prevalence of infectious diseases such as HIV and hepatitis C virus (HCV) infections and

tuberculosis. Disparities in social determinants of health affecting groups that are disproportionately likely to be incarcerated — racial minorities, persons who are unstably housed, persons with substance use disorders or mental illness — lead to greater concentrations of these illnesses in incarcerated populations. Yet implementation of interventions to address these conditions is often challenging in correctional settings owing to resource limitations and policy constraints. Therefore, comprehensive responses that straddle correctional facilities and the community often need to be devised.

For example, HCV, which is the most prevalent infectious disease in incarcerated populations,

is most commonly spread through injection drug use. Transmission can be reduced using measures known to reduce high-risk behaviors, such as opioid agonist therapy and syringe exchange. Although much of the country has yet to implement these strategies in correctional settings, managing transitions in care to and from the community and providing such services to people after incarceration has a large impact. Similarly, we have learned that controlling infections such as HIV and HCV in correctional settings can have positive effects both in these settings and on surrounding communities, as a form of treatment as prevention.

Highly transmissible novel respiratory pathogens pose a new challenge for incarcerated populations because of the ease with which they spread in congregate settings. Perhaps most relevant to the Covid-19 pandemic, the 2009 H1N1 influenza pandemic

exposed the failure to include jails in planning efforts. By the spring of 2010, vaccine was plentiful, yet most small jails never received vaccine, despite the presence of high-risk persons, such as pregnant women, and the increased risk of transmission among unvaccinated persons who spent time detained in close proximity to one another.²

“Social distancing” is a strategy for reducing transmission and “flattening the curve” of cases entering the health care system. Although correctional facilities face risks similar to those of community health care systems, social distancing is extremely challenging in these settings. Furthermore, half of all incarcerated persons have at least one chronic disease,³ and according to the U.S. Department of Justice, 81,600 are over the age of 60, factors that increase the risk of poor outcomes of infection. With limited ability to protect themselves and others by self-isolating, hundreds of thousands of susceptible people are at heightened risk for severe illness.

To date, the Federal Bureau of Prisons and certain states and municipalities have opted to suspend visitation by community members, limit visits by legal representatives, and reduce facility transfers for incarcerated persons. To reduce social isolation and maintain a degree of connectedness for incarcerated people, some correctional systems are providing teleconferencing services for personal and legal visits. Irrespective of these interventions, infected persons — including staff members — will continue to enter correctional settings. By March 14, some U.S. correctional staff members had tested posi-

tive for SARS-CoV-2, and the first Covid-19 diagnosis in a detained person was announced on March 16. A recent SARS-CoV-2 outbreak among cruise-ship passengers and crew in Yokohama, Japan, provides a warning about what could soon happen in correctional settings.⁴

To operationalize a response for incarcerated populations, three levels of preparedness need to be addressed: the virus should be delayed as much as possible from entering correctional settings; if it is already in circulation, it should be controlled; and jails and prisons should prepare to deal with a high burden of disease. The better the mitigation job done by legal, public health, and correctional health partnerships, the lighter the burden correctional facilities and their surrounding communities will bear. We have learned from other epidemics, such as the 1918 influenza pandemic, that nonpharmaceutical interventions are effective, but they have the greatest impact when implemented early.⁵

Therefore, we believe that we need to prepare now, by “decarcerating,” or releasing, as many people as possible, focusing on those who are least likely to commit additional crimes, but also on the elderly and infirm; urging police and courts to immediately suspend arresting and sentencing people, as much as possible, for low-level crimes and misdemeanors; isolating and separating incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; hospitalizing those who are seriously ill; and identifying correctional staff and health care providers who became infected early and have recovered,

who can help with custodial and care efforts once they have been cleared, since they may have some degree of immunity and severe staff shortages are likely.

All these interventions will help to flatten the curve of Covid-19 cases among incarcerated populations and limit the impact of transmission both inside correctional facilities and in the community after incarcerated people are released. Such measures will also reduce the burden on the correctional system in terms of stabilizing and transferring critically ill patients, as well as the burden on the community health care system to which such patients will be sent. Each person needlessly infected in a correctional setting who develops severe illness will be one too many.

Beyond federal, state, and local action, we need to consider the impact of correctional facilities in the global context. The boundaries between communities and correctional institutions are porous, as are the borders between countries in the age of mass human travel. Despite security at nearly every nation's border, Covid-19 has appeared in practically all countries. We can't expect to find sturdier barriers between correctional institutions and their surrounding communities in any affected country. Thus far, we have witnessed a spectrum of epidemic responses from various countries when it comes to correctional institutions. Iran, for example, orchestrated the controlled release of more than 70,000 prisoners, which may help “bend the curve” of the Iranian epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons. Reports have also emerged of in-

carceration of exposed persons for violating quarantine, a practice that will exacerbate the very problem we are trying to mitigate. To respond to this global crisis, we need to consider prisons and jails as reservoirs that could lead to epidemic resurgence if the epidemic is not adequately addressed in these facilities everywhere.

As with general epidemic preparedness, the Covid-19 pandemic will teach us valuable lessons for preparedness in correctional settings. It will also invariably highlight the injustice and inequality in the United States that are magnified in the criminal justice system. As U.S. criminal justice reform continues to unfold, emerging communicable diseases and our ability to combat them need to be taken into account. To promote public health,

we believe that efforts to decarcerate, which are already under way in some jurisdictions, need to be scaled up; and associated reductions of incarcerated populations should be sustained. The interrelation of correctional-system health and public health is a reality not only in the United States but around the world.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Medicine, Divisions of General Internal Medicine and Infectious Diseases, Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY (M.J.A.); the Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta (A.C.S.); and the Departments of Medicine and Epidemiology, Division of Infectious Diseases, Brown University and the Miriam Hospital, Providence, RI (J.D.R.).

This article was published on April 2, 2020, at NEJM.org.

1. Kaeble D, Cowhig M. Correctional populations in the United States, 2016. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, April 2018 (<https://www.bjs.gov/content/pub/pdf/cpus16.pdf>).
2. Lee AS, Berendes DM, Seib K, et al. Distribution of A(H1N1)pdm09 influenza vaccine: need for greater consideration of smaller jails. *J Correct Health Care* 2014;20:228-39.
3. Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011–12. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. February 2015 (<https://www.bjs.gov/content/pub/pdf/mpsfpi1112.pdf>).
4. Kakimoto K, Kamiya H, Yamagishi T, Matsui T, Suzuki M, Wakita T. Initial investigation of transmission of COVID-19 among crew members during quarantine of a cruise ship — Yokohama, Japan, February 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69:312-3.
5. Hatchett RJ, Mecher CE, Lipsitch M. Public health interventions and epidemic intensity during the 1918 influenza pandemic. *Proc Natl Acad Sci USA* 2007;104:7582-7.

DOI: 10.1056/NEJMp2005687

Copyright © 2020 Massachusetts Medical Society.

The Washington Post

Democracy Dies in Darkness



We must release prisoners to lessen the spread of coronavirus

By **Josiah Rich**, **Scott Allen** and **Mavis Nimoh**

March 17, 2020 at 4:01 p.m. EDT

Josiah Rich is professor of medicine and epidemiology at Brown University. Scott Allen is professor of medicine emeritus at the University of California at Riverside. Mavis Nimoh is executive director of the Center for Prisoner Health and Human Rights at the Miriam Hospital, of which Rich and Allen are co-founders.

Unless government officials act now, the novel coronavirus will spread rapidly in our jails and prisons, endangering not only prisoners and corrections workers but the general public as well. As the country prepares for further spread of the pandemic, authorities should take immediate steps to limit the risk posed by mass confinement, including releasing those detained on bail, along with elderly prisoners who pose little danger to the public.

Early on in this pandemic, we learned that, as with other closed spaces such as cruise ships and nursing homes, the covid-19 coronavirus spread rapidly in Chinese correctional facilities. Now the United States, which leads the world when it comes to incarceration, faces that same challenge.

AD

It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. People continuously enter and leave, including multiple shifts of corrections staff; newly arrested, charged and sentenced individuals; attorneys; and visitors. Even if this flow is limited to the extent possible, correctional facilities remain densely populated and poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

At the same time, jails and prisons house individuals at higher risk than in other settings, such as schools and restaurants, that have been closed to mitigate contamination. Although corrections facilities cannot be closed, they must be included in any plan aimed at slowing the surge in infections and protecting public safety.

Reassessing security and public health risks and acting immediately will save the lives of not only those incarcerated but also correctional staff and their families and the community at large. There are several steps that authorities should implement as quickly as possible.

AD

They must screen incoming individuals to prevent and delay infected individuals from entering facilities. They must rapidly identify cases and isolate exposed groups to limit the spread, as well as quickly transfer seriously ill patients to appropriate facilities.

But that won't be enough. Authorities should release those who do not pose an immediate danger to public safety, while also reducing arrests and delaying sentencings. These moves carry inherent political risks, but they are for the greater good of the public at large. The abrupt onset of severe covid-19 infections among incarcerated individuals will require mass transfers to local hospitals for intensive medical and ventilator care — highly expensive interventions that may soon be in very short supply. Each severely ill patient coming from corrections who occupies an ICU bed will mean others may die for inability to obtain care.

Our ability to release people rapidly will vary by type of facility and jurisdiction. Those being held in jails simply due to their inability to afford bail, or for minor infractions or violations, can generally be released promptly by the judiciary or even the local sheriff. Some jurisdictions are already discussing such mitigation efforts.

AD

Already sentenced individuals pose a greater challenge — one compounded by the punitive policies of the past few decades (mandatory minimum sentences, three strikes and life without parole) that have led to a large, aging incarcerated population especially vulnerable to severe disease. Additionally, half of all incarcerated people suffer from at least one chronic illness, which means even more will be at risk of a poor prognosis if they become infected.

Those eligible for parole can and should be released. Provisions for “compassionate release/parole” exist in every state; however, that process is typically slow, underutilized and very limited. Fortunately, the people at highest risk for severe complications of covid-19 who are incarcerated (the aging and chronically ill), are, on average, the least likely to commit a new crime or need to be re-incarcerated. In some states, governors have the ability to commute sentences or pardon individuals, as does the president in the federal system.

On the federal level as well, there is a parallel public health danger lurking in the immigration detention system, where thousands of people are being held in jail-like conditions that pose similar risks. The Trump administration could, if it wished, institute a simple and even temporary policy change to release those individuals into the community rather than contain them in an environment where rapid spread is likely. As unlikely as this may be given the administration’s approach to immigration detention, this may be the easiest fix, given the broad discretion of the Department of Homeland Security to change policy.

AD

The spread of the coronavirus may only be the tipping point for what can happen when we fail to consider all the costs and consequences of our system of mass incarceration. We justify locking people up to protect public safety. Yet public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in jails, prisons and detention facilities during a pandemic.

Read more:

[The Post's View: Officials must work quickly to help prevent the coronavirus in prisons](#)

[Katrina vanden Heuvel: The coronavirus makes a powerful case for boosting our social safety net](#)

[Hugh Hewitt: Senate Republicans must go big and fast in their response to the coronavirus](#)

AD

[Jennifer Rubin: What lessons will we learn from the coronavirus crisis?](#)

Susan Athey and Dean Karlan: How to practice social distancing while helping the economy

Coronavirus: What you need to read

The Washington Post is providing some coronavirus coverage free, including:

Updated April 20, 2020

Live updates: The latest in the U.S. and abroad

Mapping the spread: Cases and deaths in the U.S. | Map of cases worldwide

What you need to know: Stay-at-home orders by state | Stimulus checks, unemployment, retirement and more | Make your own fabric mask | Follow all of our coronavirus coverage and sign up for our daily newsletter.

How to help: Your community | Seniors | Restaurants | Keep at-risk people in mind

Share your story: Has someone close to you died from covid-19?

EXHIBIT D

AFFIDAVIT OF BRIE WILLIAMS, M.D.

I, Brie Williams, hereby affirm as follows:

1. I am a doctor licensed to practice medicine in the State of California.
2. I am currently a Professor of Medicine at the University of California, San Francisco (“UCSF”) in the Geriatrics Division, Director of UCSF’s Amend: Changing Correctional Culture Program, as well as Director of UCSF’s Criminal Justice & Health Program. In that capacity, my clinical research has focused on improved responses to disability, cognitive impairment, and symptom distress in older or seriously ill prisoners; a more scientific development of compassionate release policies; and a broader inclusion of prisoners in national health datasets and in clinical research. I have developed new methods for responding to the unique health needs of criminal justice-involved older adults—including an evidence-based approach to reforming compassionate release policies and the design of a new tool to assess physical functioning in older prisoners. I was previously a consultant for the California Department of Corrections and Rehabilitation, as well as for other state prison systems.
3. I have extensive experience working with vulnerable populations, in particular the incarcerated and the elderly.

The Risk of Infection and Accelerated Transmission of COVID-19 within Jails and Prisons is Extraordinarily High.

4. Prisons and jails are not actually isolated from our communities: hundreds of thousands of correctional officers and correctional healthcare workers enter these facilities every day, returning to their families and to our communities at the end of their shifts, bringing back and forth to their families and neighbors and to incarcerated patients any exposures they have had during the day. Access to testing for correctional staff has been “extremely limited,”

guards—including, as I understand, those in Connecticut—have reported a very “short supply” of protective equipment, and prisons are not routinely or consistently screening correctional officers for symptoms.¹

5. The risk of exposure is particularly acute in pre-trial facilities where the inmate populations shift frequently.² For example, despite the federal government’s guidance to stay inside and many states’ stay-in-place orders, many prosecutors are still arresting individuals and seeking detention.³ Pre-trial detention facilities are still accepting new inmates who are coming from communities where COVID-19 infection is rampant.

6. Because inmates live in close quarters, there is an extraordinarily high risk of accelerated transmission of COVID-19 within jails and prisons. Inmates share small cells, eat together and use the same bathrooms and sinks. In dorm settings, they eat together at small tables that are cleaned only irregularly. Some are not given tissues or sufficient hygiene supplies.⁴

¹ Keegan Hamilton, *Sick Staff, Inmate Transfers, and No Tests: How the U.S. Is Failing Federal Inmates as Coronavirus Hits*, Vice (Mar. 24, 2020), https://www.vice.com/en_ca/article/jge4vg/sick-staff-inmate-transfers-and-no-tests-how-the-us-is-failing-federal-inmates-as-coronavirus-hits.

See also Daniel A. Gross, “*It Spreads Like Wildfire*”: *The Coronavirus Comes to New York’s Prisons*, The New Yorker (Mar. 24, 2020), <https://www.newyorker.com/news/news-desk/it-spreads-like-wildfire-covid-19-comes-to-new-yorks-prisons>; Josiah Bates, “*We Feel Like All of Us Are Gonna Get Corona*,” *Anticipating COVID-19 Outbreaks, Rikers Island Offers Warning for U.S. Jails, Prisons*, Time (Mar. 24, 2020), <https://time.com/5808020/rikers-island-coronavirus/>; Sadie Gurman, *Bureau of Prisons Imposes 14-Day Quarantine to Contain Coronavirus*, WSJ (Mar. 24, 2020), <https://www.wsj.com/articles/bureau-of-prisons-imposes-14-day-quarantine-to-contain-coronavirus-11585093075>; Cassidy McDonald, *Federal Prison Workers Say Conflicting Orders on Coronavirus Response Is Putting Lives at Risk*, CBS News (Mar. 19, 2020), <https://www.cbsnews.com/news/coronavirus-prison-federal-employees-say-conflicting-orders-putting-lives-at-risk-2020-03-19/>.

² Emma Grey Ellis, *Covid-19 Poses a Heightened Threat in Jails and Prisons*, Wired (Mar. 24, 2020), <https://www.wired.com/story/coronavirus-covid-19-jails-prisons/>.

³ Stephen Rex Brown, “*Business as Usual*” *For Federal Prosecutors Despite Coronavirus*, Nadler Writes, *Calling for Release of Inmates*, N.Y. Daily News (Mar. 20, 2020), <https://www.nydailynews.com/new-york/ny-nadler-doj-inmates-20200320-d6hbdjcujsaitppi3ui2xz7tjy-story.html>.

⁴ Justine van der Leun, *The Incarcerated Person Who Knows How Bad It Can Get*, Medium (Mar. 19, 2020), <https://gen.medium.com/what-its-like-to-be-in-prison-during-the-coronavirus-pandemic-1e770d0ca3c5> (“If you don’t have money, you don’t have soap or tissues.”); Keri Blakinger and Beth Schwartzapfel, *How Can Prisons Contain Coronavirus When Purrell Is a Contraband?*, ABA Journal (Mar. 13, 2020), <https://www.abajournal.com/news/article/when-purrell-is-contraband-how-can-prisons-contain-coronavirus>.

Effective social distancing in most facilities is virtually impossible, and is often compounded by inadequate sanitation, such as a lack of hand sanitizer or sufficient opportunities to wash hands.⁵

Inmate Populations Also Have the Highest Risk of Acute Illness and Poor Health Outcomes if Infected with COVID-19.

7. There are more than 2.3 million people incarcerated in the United States⁶ approximately 16% of whom are age 50 or older.⁷ The risk of coronavirus to incarcerated seniors is high. “Their advanced age, coupled with the challenges of practicing even the most basic disease prevention measures in prison, is a potentially lethal combination.”⁸ To make matters worse, correctional facilities are often ill-equipped to care for aging prisoners, who are more likely to suffer from chronic health conditions than the general public.

8. An estimated 39-43% of all prisoners, and over 70% of older prisoners, have at least one chronic condition, some of the most common of which are diabetes, hypertension, and heart problems.⁹ According to the CDC, each of these conditions—as well as chronic bronchitis,

⁵ Rosa Schwartzburg, *The Only Plan the Prison Has Is to Leave Us To Die in Our Beds*, The Nation (Mar. 25, 2020), <https://www.thenation.com/article/society/coronavirus-jails-mdc/>.

⁶ Kimberly Kindy *et al.*, *‘Disaster Waiting to Happen’: Thousands of Inmates Released as Jails and Prisons Face Coronavirus Threat*, Washington Post (Mar. 25, 2020), https://www.washingtonpost.com/national/disaster-waiting-to-happen-thousands-of-inmates-released-as-jails-face-coronavirus-threat/2020/03/24/761c2d84-6b8c-11ea-b313-df458622c2cc_story.html.

⁷ Brie Williams *et al.*, *Strategies to Optimize the Use of Compassionate Release from US Prisons*, 110 AJPH S1, S28 (2020), available at <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2019.305434>; Kimberly A. Skarupski, *The Health of America’s Aging Prison Population*, 40 Epidemiologic Rev. 157, 157 (2018), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5982810/>.

⁸ Weihua Li and Nicole Lewis, *This Chart Shows Why the Prison Population is So Vulnerable to COVID-19*, The Marshall Project (Mar. 19, 2020), <https://www.themarshallproject.org/2020/03/19/this-chart-shows-why-the-prison-population-is-so-vulnerable-to-covid-19>.

⁹ Brie A. Williams *et al.*, *How Health Care Reform Can Transform the Health of Criminal Justice-Involved Individuals*, 33 Health Affairs 462-67 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4034754/>; Brie A. Williams *et al.*, *Coming Home: Health Status and Homelessness Risk of Older Pre-release Prisoners*, 25 J. Gen. Internal Med. 1038-44 (2010), available at <https://link.springer.com/content/pdf/10.1007/s11606-010-1416-8.pdf>; Laura M. Maruschak *et al.*, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12*, U.S. Dept of Justice (Oct. 4, 2016), at 5, available at <https://www.bjs.gov/content/pub/pdf/mpsfj1112.pdf>.

emphysema, heart failure, blood disorders, chronic kidney disease, chronic liver disease, any condition or treatment that weakens the immune response, current or recent pregnancy in the last two weeks, inherited metabolic disorders and mitochondrial disorders, heart disease, lung disease, and certain neurological and neurologic and neurodevelopment conditions¹⁰—puts them at a “high-risk for severe illness from COVID-19.”¹¹

9. However, even many young federal prisoners suffer from asthma, rendering them also very vulnerable to coronavirus.¹²

10. But it is not only the elderly, or those with preexisting medical conditions that are at risk of coronavirus in a correctional setting. As of March 23, 2020, New York City reported that “[p]eople ranging in ages from 18 to 44 have accounted for 46 percent of positive tests.”¹³ Across the United States, 38% of those hospitalized are between the ages of 20 and 54 and 12% of the intensive care patients are between 20 and 44.¹⁴

11. This data is of particular concern for inmate populations, since prisoners’ physiological age *averages 10 to 15 years older* than their chronological age.¹⁵ Therefore, the

¹⁰ Harvard Health Publishing, *Coronavirus Research Center*, Harvard Medical School (Mar. 25, 2020), <https://www.health.harvard.edu/diseases-and-conditions/coronavirus-resource-center>.

¹¹ Centers for Disease Control and Prevention, *Coronavirus Disease 2019: People Who Are at Higher Risk*, <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html> (last updated Mar. 22, 2020).

¹² Laura Maruschak, *Medical Problems of Jail Inmates*, Dep’t of Justice (Nov. 2006), at p. 2, *available at* <https://www.bjs.gov/content/pub/pdf/mpji.pdf>.

¹³ Kimiko de Freytas-Tamura, *20-Somethings Now Realizing That They Can Get Coronavirus, Too*, N.Y. Times (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/nyregion/nyc-coronavirus-young.html>.

¹⁴ *Id.*

¹⁵ Brie A. Williams *et al.*, *Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care*, 102 Am. J. Public Health 1475-81 (2012), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842/>; *see also* Brie Williams *et al.*, *Detained and Distressed: Persistent Distressing Symptoms in a Population of Older Jail Inmates*, 64 J. Am. Geriatrics Soc. 2349-55 (2016), <https://onlinelibrary.wiley.com/doi/pdf/10.1111/jgs.14310> (“For example, older jail inmates with an average age of 60 in this study reported poor or fair health [and] chronic

consensus of those who study correctional health is that inmates are considered “geriatric, by the age of 50 or 55 years.”¹⁶ It is not clear that prison health care administrations are taking accelerated ageing into account when determining the eligibility criteria for age-related screening tools and medical care protocols for coronavirus, potentially leaving large swathes of the prison population at risk.¹⁷

12. In one study, we found that inmates who died in hospitals were, on average, nearly two decades younger than non-incarcerated decedents, had significantly shorter hospitalizations, and had higher rates of several chronic conditions including cancer, liver disease and/or hepatitis, mental health conditions, and HIV/AIDS.”¹⁸

The Entire Community is at Risk If Prison Populations Are Not Reduced

13. As the World Health Organization has warned, prisons around the world can expect “huge mortality rates” from Covid-19 unless they take immediate action including screening for the disease.¹⁹

lung disease . . . at rates similar to those reported by community-based lower income older adults with an average age of 72.”).

¹⁶ Brie A. Williams *et al.*, *The Older Prisoner and Complex Chronic Medical Care* 165-70 in World Health Organization, *Prisons and Health* (2014), <https://pdfs.semanticscholar.org/64aa/10d3cff6800ed42dd152fcf4e13440b6f139.pdf>.

¹⁷ Brie A. Williams *et al.*, *Differences Between Incarcerated and Non-Incarcerated Patients Who Die in Community Hospitals Highlight the Need For Palliative Care Services For Seriously Ill Prisoners in Correctional Facilities and in Community Hospitals: a Cross-Sectional Study*, 32 J. Palliative Med. 17-22 (2018), available at <https://journals.sagepub.com/doi/pdf/10.1177/0269216317731547>.

¹⁸ *Id.* at 20.

¹⁹ Hannah Summers, ‘Everyone Will Be Contaminated’: Prisons Face Strict Coronavirus Controls, *The Guardian* (Mar. 23, 2020), <https://www.theguardian.com/global-development/2020/mar/23/everyone-will-be-contaminated-prisons-face-strict-coronavirus-controls>.

14. Jails and prisons are fundamentally ill-equipped to handle a pandemic. Medical treatment capacity is not at the same level in a correctional setting as it is in a hospital. Some correctional facilities have no formal medical ward and no place to quarantine sick inmates, other than the facilities' Special Housing Unit (SHU).²⁰ While the cells in the SHU often have solid doors to minimize the threat of viral spread in otherwise overcrowded facilities, they rarely have intercoms or other ways for sick inmates to contact officers in an emergency.²¹ This is particularly dangerous for those with COVID-19 infection since many patients with COVID-19 descend suddenly and rapidly into respiratory distress.²²

15. Even those facilities that do have healthcare centers can only treat relatively mild types of respiratory problems for a very limited number of people.²³ This means that people who become seriously ill while in prisons and jails will be transferred to community hospitals for care. At present, access to palliative care in prison is also limited.

16. Corrections officers may also be particularly vulnerable to coronavirus due to documented high rates of diabetes and heart disease.²⁴ Multiple prison staff in Connecticut, like those in Pennsylvania, Michigan, New York and Washington state, among others, have tested

²⁰ MCC New York COVID 19 Policy Memo, Mar. 19, 2020, <https://www.documentcloud.org/documents/6818073-MCC-New-York-COVID-19-Policy-Memo.html>; Danielle Ivory, 'We Are Not a Hospital': A Prison Braces for the Coronavirus, N.Y. Times (Mar. 17, 2020), <https://www.nytimes.com/2020/03/17/us/coronavirus-prisons-jails.html>.

²¹ Brie Williams *et al.*, *Correctional Facilities in the Shadow of COVID-19: Unique Challenges and Proposed Solutions*, Health Affairs (Mar. 26, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200324.784502/full/>.

²² Lizzie Presser, *A Medical Worker Describes Terrifying Lung Failure From COVID-19—Even in His Young Patients*, ProPublica (Mar. 21, 2020), <https://www.propublica.org/article/a-medical-worker-describes--terrifying-lung-failure-from-covid19-even-in-his-young-patients>.

²³ Ellis, *Covid-19 Poses a Heightened Threat in Jails and Prisons*; Li and Lewis, *This Chart Shows Why the Prison Population is So Vulnerable to COVID-19*.

²⁴ Brie Williams, *Role of US-Norway Exchange in Placing Health and Well-Being at the Center of US Prison Reform*, <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305444> (published Jan. 22, 2020).

positive for the virus, resulting in inmate quarantines. Fifty-nine federal prison staffers have also tested positive.²⁵

17. For this reason, correctional health is public health. Decreasing risk in prisons and jails decreases risk to our communities.

18. Reducing the overall population within correctional facilities will also help medical professionals spread their clinical care services throughout the remaining population more efficiently. With a smaller population to manage and care for, healthcare and correctional leadership will be better able to institute shelter in place and quarantine protocols for those who remain. This will serve to protect the health of both inmates as well as correctional and healthcare staff.



Dr. Brie Williams

San Francisco, California
April 6, 2020

-Notarized copy to follow-

²⁵ Board of Prisons, Open COVID-19 Tested Positive Cases, <https://www.bop.gov/coronavirus>.