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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

LANCE AARON WILSON; MAURICE SMITH; EDGAR VASQUEZ, individually and on behalf of all others similarly situated,

Plaintiff-Petitioners,

vs.

FELICIA L. PONCE, in her capacity as Warden of Terminal Island; and MICHAEL CARVAJAL, in his capacity as Director of the Bureau of Prisons,

Defendant-Respondents.

CASE NO.

COMPLAINT—CLASS ACTION FOR DECLARATORY AND INJUNCTIVE RELIEF AND PETITION FOR WRIT OF HABEAS CORPUS

Immediate Relief Requested

I.

INTRODUCTION

1. One week ago today, Scott Cutting became the seventh incarcerated person to die due to complications from coronavirus at FCI Terminal Island.[1] Despite being 70 years old, having preexisting conditions, and showing symptoms for days, he was not tested for coronavirus until his symptoms were so severe that he had to be placed on a ventilator. He was serving a 26-month sentence when he died.

2. On Wednesday, May 13, 2020, James Lino, became the eighth incarcerated person to die due to complications from coronavirus at Terminal Island.[2] He was at Terminal Island in part due to his long-term preexisting conditions. Lino was 65 years old and serving a 34-month sentence when he died.

3. It was precisely in anticipation of cases like those of Mr. Cutting and Mr. Lino that Congress modified 18 U.S.C. § 3624(c) under Section 12003(b)(2) of the Coronavirus Aid, Relief, and Economic Security ("CARES") Act to broaden the Federal Bureau of Prison's ("BOP") discretion to allow home confinement during the COVID-19 emergency period. While BOP previously could only authorize home confinement for those who had the shorter of 6 months or 10% of their sentences left to serve, the CARES Act removed those limitations and allows the BOP to authorize home confinement for any amount of time within its discretion. After having initially provided a list of criteria for BOP to consider when releasing prisoners into home confinement, Attorney General William Barr issued a second

[1] *Nearly 70% of Terminal Island inmates test positive for coronavirus as 7th inmate dies*, Daily Breeze, May 9, 2020, https://www.dailybreeze.com/2020/05/09/nearly-70-of-terminal-island-inmates-test-positive-for-coronavirus-as-7th-inmate-dies/

[2] *8th inmate dies of coronavirus at Terminal Island federal prison*, Daily Breeze, May 13, 2020, https://www.dailybreeze.com/2020/05/13/8th-inmate-dies-of-coronavirus-at-terminal-island-federal-prison/

memo on April 3, 2020, weeks before Mr. Cutting and Mr. Lino died, urging the BOP to immediately transfer medically "at-risk" prisoners to home confinement, especially at facilities where "COVID-19 is materially affecting operations."[3] Under that criteria, Mr. Cutting and Mr. Lino, both of whom were 65 or older and had pre-existing health conditions, should have been on the shortlist for home confinement. But the BOP and Terminal Island did not release them.

4. This petition is not brought by Mr. Cutting or Mr. Lino, who have died. This petition is brought by Plaintiff-Petitioner Lance Aaron Wilson, Plaintiff-Petitioner Maurice Smith, and Plaintiff-Petitioner Edgar Vasquez (collectively, "Petitioners") on behalf of themselves and a class of all medically vulnerable persons incarcerated at Terminal Island now and in the future, who are all still alive and incarcerated at Terminal Island and seek to avoid Mr. Cutting and Mr. Lino's fate.

5. Terminal Island is a low-security correctional institution within the BOP that is supposed to specialize in housing prisoners who need long-term medical or mental health care.[4] Terminal Island houses some of most vulnerable—and least dangerous—people serving time caught in the federal prison system. The cruel irony is that many of the people currently imprisoned in Terminal Island were sent there *because* they have serious medical conditions. They were sent to Terminal Island to get access to superior medical care—but instead, they are now housed in one of the

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[3] *Memorandum for Director of Bureau of Prisons*, Office of the Attorney General, Washington D.C. (March 26, 2020) *available at* https://www.bop.gov/coronavirus/docs/bop_memo_home_confinement.pdf; *Memorandum for Director of Bureau of Prisons*, Office of the Attorney General, Washington, D.C. (April 3, 2020) *available at* https://www.bop.gov/coronavirus/docs/bop_memo_home_confinement_april3.pdf

[4] Jeremiah Dobruck, *Man serving 26 months for tax fraud is 7th Terminal Island inmate to die*, LONG BEACH POST NEWS, May 10, 2020, *available at* https://lbpost.com/news/terminal-island-inmate-dies-7th-700

deadliest facilities in the BOP. Given the overwhelming number of people infected, it is impossible for Terminal Island to provide proper medical treatment. At least eight people incarcerated at Terminal Island have already died from complications related to the coronavirus.

6. Just a week ago, Terminal Island was the site of the largest COVID-19 outbreak at a BOP facility, reporting over 700 positive cases (693 prisoners and 15 staff) as recently as May 11, 2020. By May 15, the number of prisoners mysteriously dropped to 129, with 569 prisoners now being categorized as suddenly being "recovered." As of the morning of May 15, 2020, when accounting for both prisoners who are being reported as "positive" and those being reported as "recovered," BOP reports a total of 697 out of the 1,042 individuals incarcerated at Terminal Island as having recently tested positive for coronavirus—more than every state prison in California combined.[5]

7. The Court must intervene to prevent Terminal Island from becoming the site of a national tragedy. Respondents Michael Carvajal, the Director of the BOP, and Felicia L. Ponce, the Warden of Terminal Island, have demonstrated that they cannot or will not take the measures necessary to prevent the coronavirus from converting more prison sentences into death sentences without court intervention. Despite numerous warning signs, and despite demands for answers and action by federal, state, and local politicians, Respondents have completely failed to prevent the deadly coronavirus from spreading rampantly through Terminal Island, including by failing to provide basic supplies like soap and hand sanitizer, refusing to provide adequate personal protective equipment (PPE) to prisoners and staff, and failing to conduct enough testing until it was too late. Most egregiously,

[5] *See* Federal Bureau of Prisons, COVID-19 Coronavirus, https://www.bop.gov/coronavirus/ (last accessed May 15, 2020) *compare* California Department of Corrections and Rehabilitation, COVID-19 Preparedness, https://www.cdcr.ca.gov/covid19/ (last accessed May 15, 2020).

Respondents have refused to exercise the wide discretion given to them by Congress during this national emergency to release low-risk offenders to home confinement in order to save lives. Having allowed the majority of Terminal Island prisoners to contract the virus, Respondents cannot be trusted to provide those who have tested positive with proper medical treatment or to protect those who remain uninfected from infection.

8. It is clear from the public record that Respondents will not act to meet the bare minimum requirements of the Constitution unless forced to do so. On March 21, 2020, BOP reported the first case of a prisoner testing positive for COVID-19. Although public health officials warned that BOP was walking into a "disaster waiting to happen[,]" BOP claimed that it was "confident" in its " robust efforts to keep correctional workers and the inmate population safe and healthy[.]"[6] A little over a month later, BOP's own statistics show that this confidence was sorely misplaced. As of this morning, BOP now reports that 4,170 people incarcerated in BOP facilities and 562 staff members have tested positive for COVID-19. 55 people in BOP custody have died.[7] The spread of COVID-19 within the enclosed space of federal prisons has now exploded into a veritable outbreak that threatens the health and safety of not only every person residing therein "but also corrections officers and prison health-care workers as well as their families and communities."[8]

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[6] Kimberly Kindy, Emma Brown, Dalton Bennett, *'Disaster waiting to happen': Thousands of inmates released as jails and prisons face coronavirus threat*, WASHINGTON POST, March 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] Federal Bureau of Prisons, COVID-19 Coronavirus, https://www.bop.gov/coronavirus/

[8] *Kindy, et al., supra*.

9. The Warden's claims that the outbreak is under control ring hollow. Those imprisoned inside Terminal Island report being crammed into communal living areas with less than 2-3 feet of space between bunks. The BOP denied requests from staff for PPE because it could "scare the inmates."[9] Sick prisoners have been released from medical care prematurely, only to collapse again. Other prisoners who have tested positive and have symptoms have received no medical care at all—they are not being appropriately monitored and they have not even been able to speak with a doctor about how they are feeling, how bad their symptoms are likely to become or what their treatment options are. The grim results speak for themselves. Over half the inmate population have been infected. People have died, and more are dying.

10. COVID-19 has changed the way we live our lives, almost overnight. In California, since March 19, 2020, Governor Gavin Newsom has imposed an order for all California residents to stay at home except to address essential needs.[10] Citizens in every state and almost every country in the world are accepting unprecedented disruptions to their everyday lives in order to minimize human contact through social distancing and to ensure that governments are able to test, track, treat, and isolate those infected with COVID-19.

11. The same practices that are saving lives across the world, however, are simply not possible for the 1,000+ people trapped inside of Terminal Island. Packed into the confines of their shared dormitories, those imprisoned in Terminal Island spend almost every moment of every day within arms-length of another person—

[9] *Goldstein Investigates: Terminal Island Inmate Families Protest Prison Conditions After 5 Die From Coronavirus*, CBS Los Angeles (May 1, 2020), https://losangeles.cbslocal.com/2020/05/01/goldstein-investigates-terminal-island-inmate-families-protest-prison-conditions-after-5-die-from-coronavirus/

[10] California Coronavirus (COVID-19) Response, Stay home except for essential needs, https://covid19.ca.gov/stay-home-except-for-essential-needs/

whether it be while standing in pill lines, taking meals, or even when sleeping. The Prison has been unable to effectively isolate infected individuals from the general population. The Prison did not issue masks to its inmates until the end of April, and prisoners were forced to reuse those masks for at least a week.

12. Far from learning from its missteps at Terminal Island, the BOP continues to demonstrate a callous disregard for reality, claiming on a recent staff-wide call, without basis, that the shocking number of positive cases at facilities such as Terminal Island are "in no way representative of the positive rate across the agency."[11] Having only recently increased testing due to mounting political pressure, Respondents are now overwhelmed and have no plan to control or contain the outbreak at Terminal Island or to treat the hundreds of prisoners who have now contracted the virus. Petitioners cannot afford to wait and see if Respondents will handle the treatment of coronavirus better than they handled the prevention of its spread. Unless immediate action is taken to ensure that Terminal Island provides proper medical care to those infected and implements measures to protect those who are not yet infected, including by reducing the size of the incarcerated population, soon, substantially all incarcerated people at Terminal Island—many of whom are especially vulnerable due to underlying medical conditions—will be infected with COVID-19. Some will die. Dr. Shamsher Samra, a noted physician with ample experience working with incarcerated individuals, delivers an urgent warning: "BOP should take ***immediate steps*** to dramatically downsize the population at Terminal Island, with priority given to those at high risk of harm due to their age and health status and thus are likely to require a disproportionate amount of medical resources**.**"[12]

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[11] *Federal Bureau of Prisons*, Director M.D. Carvajal Addresses All Staff (May 6, 2020), https://www.bop.gov/resources/news/20200506_dir_message.jsp

[12] Exhibit 5 ("Exh. 5," Declaration of Shamsher Samra, M.D.) ¶ 20 (emphasis added); *accord* Exhibit 6 ("Exh. 6," Declaration of Marc Stern, M.D.) ¶ 17.

13. Despite their expanded power to release more prisoners under the CARES Act, Respondents are refusing to consider home confinement for the vast majority of those incarcerated at Terminal Island. For many, the actions and inactions of Respondents will lead to a death sentence. This deliberate indifference amounts to cruel and unusual punishment prohibited by the Eighth Amendment.

14. Time is running out for the individuals incarcerated at Terminal Island. Every day, those infected fear for their lives. Every day, those who are not infected see people succumbing to the illness and are forced to face the inescapable reality that it will soon come for them as well. Help is not coming from the institution or individuals entrusted with their care. Their relief can only come from the Court, and it must come before it is too late.

15. Accordingly, Plaintiff-Petitioner Lance Aaron Wilson, Plaintiff-Petitioner Maurice Smith, and Plaintiff-Petitioner Edgar Vasquez on behalf of themselves and a class of all persons incarcerated at Terminal Island now and in the future, bring this action for declaratory and injunctive relief, for enlargement of custody to include home confinement, and ultimately, if they cannot be held in custody constitutionally, for release.

II.

PARTIES

16. Plaintiff-Petitioner Lance Aaron Wilson ("Petitioner Wilson") is incarcerated at Terminal Island. He is 35 years old and suffers from hypertension and asthma, making him especially vulnerable to complications resulting from COVID-19. Starting in mid-April, when Terminal Island went on lockdown and prisoners were forbidden from using phones and computers, Petitioner Wilson wrote a series of letters to his family describing his fear of the virus that seemed to be making everyone around him sick.[13] His final letter was sent on May 6, 2020. In

[13] *See* Exhibit 1 ("Exh. 1," Declaration of Jacque Wilson) ¶¶ 14-19.

that letter, Petitioner Wilson informed his family that he had tested positive for COVID-19, and was experiencing symptoms including migraines, body chills, and sweating in his sleep. Since then, he has not been given any treatment, nor has he been able to see a doctor. Petitioner Wilson submitted an application for Compassionate Release and/or Home Confinement to Respondent Ponce on April 27, 2020. He has not heard back.

17. Plaintiff-Petitioner Maurice Smith ("Petitioner Smith") is incarcerated at Terminal Island. He is 50 years old and suffers from asthma, hypertension, and is also pre-diabetic. After the COVID-19 outbreak began at Terminal Island, Petitioner Smith was transferred to a makeshift living space in an old UNICOR warehouse, infested with vermin and without potable water, hot water for showers, or heating. Petitioner Smith has raised concerns about the living conditions to prison staff—including the Warden—but his complaints have fallen on deaf ears. For now, he simply tries to help as many of the sick prisoners as he can.[14]

18. Plaintiff-Petitioner Edgar Vasquez ("Petitioner Vasquez") is incarcerated at Terminal Island. He is 32 years old. Around the same time as Petitioner Smith, Petitioner Vasquez was transferred to the warehouse. Due to the unsanitary conditions, he started feeling sick and became afraid that he had contracted COVID-19. Despite numerous requests for medical attention, he was ignored, and was simply told to "hang in there" because his temperature isn't high enough.

19. Respondent Felicia L. Ponce ("Respondent Ponce," "Warden Ponce," or "Warden") is the Warden at Terminal Island. As Warden, Respondent Ponce is responsible for and oversees all day-to-day activity at Terminal Island. She is in charge of all aspects of the operations and functions of Terminal Island. Her

[14] According to a communication from his wife—Jennifer Van Atta—just a few hours prior to filing of this Complaint, Petitioner Smith has now tested positive for COVID-19.

responsibilities include ensuring the safety of all in the institution and ensuring that the institution operates in an orderly fashion. Warden Ponce is aware of and has adopted and enforced policies that leave Petitioners and all those similarly situated exposed to infection, severe illness, and death due to COVID-19. Warden Ponce has also declined to release people who qualify under BOP and Department of Justice guidance despite having the authority to do so. Warden Ponce is the immediate and physical custodian responsible for the detention of the Petitioners. She is sued in her official capacity only.

20. Respondent Michael Carvajal is the Director of the Federal Bureau of Prisons ("Respondent Carvajal," "Director Carvajal," or "Director"). As Director, Respondent Carvajal is responsible for all BOP policies implemented at Terminal Island, including those pertaining to resource distribution and factors that BOP facility leadership should consider in determining an incarcerated individual's eligibility for early release. His responsibilities include ensuring the safety of all in the BOP system and ensuring that institutions operate in an orderly fashion. Director Carvajal is aware of and has adopted and enforced policies that leave Petitioners and all those similarly situated exposed to infection, severe illness, and death due to COVID-19. He is sued in his official capacity only.

III.

JURISDICTION AND VENUE

21. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 2241 because Petitioners seek relief from being held in custody in violation of the Eighth Amendment to the U.S. Constitution, and pursuant to 28 U.S.C. § 1331 for relief from conditions of confinement that are in violation of the Eighth Amendment.

22. The Court has subject-matter jurisdiction over this Petition pursuant to 28 U.S.C. § 1331 (federal question), 5 U.S.C. § 702 of the Administrative Procedure Act, 28 U.S.C. § 2241 (habeas corpus), and Article I, § 9, cl. 2 of the U.S

Constitution (Suspension Clause). In addition, the Court has jurisdiction to grant declaratory relief pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201.

Venue is proper in the Central District of California pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events and omissions giving rise to these claims occurred and continues to occur in this district.

23. This Court has personal jurisdiction over Warden Ponce because at all times relevant to this action, she has been employed at Terminal Island in Los Angeles County, California, and all the actions and omissions at issue occurred at Terminal Island. This Court has personal jurisdiction over Director Carvajal because at all times relevant to this action, he has set BOP policies and issued guidance that Respondent Ponce has applied at Terminal Island in Los Angeles County, California.

IV.

FACTUAL ALLEGATIONS

A. The COVID-19 Crisis

24. The novel coronavirus that causes COVID-19 has led to a global pandemic. As of May 15, 2020, worldwide there are over 4.3 million reported COVID-19 cases and 297,241 confirmed deaths.[15] In the United States, the case count stands at 1,412,121 and the death count at 85,990.[16] In California, there are currently 74,936 confirmed cases of coronavirus.[17] There are 5,843 individuals who

[15] World Health Org., Coronavirus disease (COVID-19) Pandemic, https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last accessed May 15, 2020).

[16] Ctrs. for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last accessed May 15, 2020).

[17] California Department of Public Health, COVID-19 Updates, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx (last accessed May 15, 2020).

have been hospitalized with confirmed or suspected cases of coronavirus and 3,108 fatalities.[18] Los Angeles County has been epicenter of the pandemic in California, with 28,644 cases and 1,367 deaths.[19]

25. The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.[20] Infected people can spread the virus to others even if they are asymptomatic, such that simply avoiding people who are coughing or visibly feverish is insufficient.

26. According to the CDC, people who suffer from certain underlying medical conditions face elevated risk.[21] Such conditions include chronic lung disease, moderate to severe asthma, serious heart conditions, hypertension, high blood pressure, chronic kidney disease, liver disease, diabetes, compromised immune systems (such as from cancer treatment, HIV, autoimmune disease, or use of immunosuppressing medication for other conditions), and severe obesity. One analysis found mortality rates of 13.2% for patients with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[22]

27. The risk of illness or death from COVID-19 is increased for older

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[18] *Id.*

[19] County of Los Angeles, COVID-19 in Los Angeles County, https://covid19.lacounty.gov/ (last accessed May 15, 2020).

[20] *See* Exh. 5 ¶ 4.

[21] CDC, Groups at Higher Risk for Severe Illness, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (last accessed May 15, 2020).

[22] World Health Org., *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* (Feb. 28, 2020) at 12, *available at* https://www.who.int/docs/default-source/coronaviruse/who- china-joint-mission-on-covid-19-final-report.pdf

populations. In a February 29, 2020 preliminary report, individuals age 50-59 had an overall mortality rate of 1.3%, those age 60-69 had an overall 3.6% mortality rate, and those age 70-79 had an 8% mortality rate.[23]

28. In many people, COVID-19 causes fever, cough, and shortness of breath. But for people over the age of fifty or with medical conditions that increase the risk of serious COVID-19 infection, shortness of breath can be severe. Most people in higher-risk categories who develop serious illness will need advanced support. This level of supportive care requires highly specialized equipment that is in limited supply, and an entire team of care providers, including 1:1 or 1:2 nurse-to-patient ratios, respiratory therapists, and intensive-care physicians.[24]

29. In patients who do not die, COVID-19 can severely damage lung tissue, requiring an extensive period of rehabilitation, and in some cases, can cause a permanent loss of respiratory capacity. COVID-19 may also target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.[25]

30. Emerging evidence also suggests that COVID-19 can trigger an over-response of the immune system, further damaging tissues in a cytokine release

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[23] Worldometer, Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart, https://cutt.ly/ytEimUQ (data analysis based on WHO China Joint Mission Report) (last accessed May 15, 2020).

[24] *See* Exh. 5 ¶ 7 (noting that treatment for vulnerable people infected by COVID-19 may require "significant advanced support" including ventilator assistance and intensive care support).

[25] Cynthia Weiss, How does COVID-19 affect the heart?, Mayo Clinic News Network (Apr. 3, 2020), https://newsnetwork.mayoclinic.org/discussion/how-does-covid-19-affect-the-heart/.

syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury. These complications can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days.[26]

31. Even some younger and healthier people who contract COVID-19 may require supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.[27]

32. The estimated fatality rate associated with COVID-19 has been estimated to range from 0.1 to 6 percent, meaning COVID-19 may be as much as 35 times more fatal than seasonal influenza.[28] Although many people who contract COVID-19 will exhibit relatively mild symptoms, the virus will manifest in some 20 percent of cases as a more severe disease requiring "significant medical intervention."[29]

33. There is no vaccine against COVID-19 and there is no known medication to prevent or treat infection from COVID-19. Social distancing, or remaining physically separated from known or potentially infected individuals, and

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[26] Lenny Bernstein et al., *Coronavirus destroys lungs. But doctors are finding its damage in kidneys, hearts and elsewhere*, Wash. Post (Apr. 15, 2020), https://www.washingtonpost.com/health/coronavirus-destroys-lungs-but-doctors-are-finding-its- damage-in-kidneys-hearts-and-elsewhere/2020/04/14/7ff71ee0-7db1-11ea-a3ee- 13e1ae0a3571_story.html; Aria Bendix, A Day-By-Day Breakdown of Coronavirus Symptoms Shows How the Disease COVID-19 Goes from Bad to Worse, Business Insider (Mar. 31, 2020), https://www.businessinsider.com/coronavirus-covid19-day-by-day-symptoms-patients-2020-2.

[27] *See* Exh. 5 ¶ 9.

[28] *See* Exh. 5 ¶ 5.

[29] *Id.*

vigilant hygiene, including frequently and thoroughly washing hands with soap and water and cleaning and disinfecting high-touch surfaces, are the only known effective measures for protecting people from COVID-19.[30] This is especially significant because the virus can spread through people who appear asymptomatic.[31]

34. State and local officials have been taking aggressive action in California. On March 4, in response to then-emerging coronavirus outbreak, Governor Newsom declared a State of Emergency in California,[32] doing so even before the President had declared a national emergency.[33] That same day, the Los Angeles County Board of Supervisors and Los Angeles County Health Officer declared a local and public health emergency.[34] On March 19, 2020, Governor Newsom issued Executive Order No. N-22-20 requiring all California residents to "stay home or at their place of residence" unless the resident works in critical infrastructure sectors. [35]

35. Local officials have also taken extraordinary measures aimed at slowing the virus's spread. For example, on March 19, Los Angeles Mayor issued a

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[30] *See* Exh. 5 ¶ 4.

[31] Exh. 5 ¶ 5.

[32] https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf

[33] *See* Charlie Savage, *Trump Declared an Emergency Over Coronavirus. Here's What It Can Do.*, N.Y. Times (Mar. 13, 2020), https://www.nytimes.com/2020/03/13/us/politics/coronavirus- national-emergency-html.

[34] *County of Los Angeles Declares Local Health Emergency in Response to New Novel Coronavirus Activity* (Mar. 4, 2020), *available at* http://www.publichealth.lacounty.gov/phcommon/public/media/mediapubhpdetail.cfm?prid=2248.

[35] CA Exec. Order No. N-22-20 (Mar. 19, 2020), *available at* https://www.gov.ca.gov/wp-content/uploads/2020/03/3.19.20-attested-EO-N-33-20-COVID-19-HEALTH-ORDER.pdf.

"Safer at Home" order ordering residents of the City of Los Angeles to remain in their homes with lawful exceptions for critical tasks such as securing food and health, safety and medical necessities.[36] Los Angeles County Health Officer Muntu Davis signed a "Safer at Home" order the same day, which prohibited all indoor public and private gatherings and all outdoor public and private events within a confined space where at least 10 people were expected to be in attendance at the same time.[37] The Los Angeles County Order was strengthened on March 21, 2020 to prohibit all gatherings and events.[38]

B. Incarcerated People and Staff Are Particularly Vulnerable.

36. People in environments with confined spaces such as correctional facilities, where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships[39] and nursing homes.[40] The close quarters and limited freedom of

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[36] Mayor of LA, *Mayor Garcetti: Angelenos are 'Safer at Home'* (March 19, 2020), https://www.lamayor.org/mayor-garcetti-angelenos-are-%E2%80%98safer-home-new-emergency-order-stops-non-essential-activities-outside

[37] County of Los Angeles Public Health, *Safer at Home Order for Control of COVID-19* (March 19, 2020) *available at* http://file.lacounty.gov/SDSInter/lac/1070029_COVID-19_SaferAtHome_HealthOfficerOrder_20200319_Signed.pdf

[38] County of Los Angeles Public Health, *Los Angeles County Announces Two New Deaths Related to 2019 Novel Coronavirus (COVID-19)* (March 23, 2020), http://www.publichealth.lacounty.gov/phcommon/public/media/mediapubhpdetail.cfm?prid=2279

[39] *E.g.*, Jason Hanna & Melissa Alonso, *Coral Princess Docks in Miami With 2 Dead and Several Ill of Coronavirus, After Ports Shunned it For Days*, CNN (Apr. 4, 2020), https://www.cnn.com/2020/04/04/us/coral-princess-cruise-ship-docks-miami- coronavirus/index.html.

[40] *E.g.*, Stacey Burling, *Assume Coronavirus is Already There, Says a Philly Nursing Home Doctor Who Learned the Hard Way*, Phila. Inquirer (Apr. 3, 2020), *available at* https://www.inquirer.com/health/coronavirus/coronavirus-renaissance-nursing-home- philadelphia-20200403.html; *see also* Suzy Khimm & Laura

movement inherent in correctional facilities makes social distancing and other preventive measures difficult or impossible. Moreover, the ability of incarcerated people to adopt preventative measures is completely subject to the dictates of correctional officials who control the housing, schedules, sanitary supplies, and nearly every other aspect of their lives.[41]

37. Correctional facilities increase the risk of rapid spread of an infectious disease, like COVID-19, because of the 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.[42]

38. The CDC has issued guidance urging prison administrators to take action to prevent overcrowding of correctional and detention facilities during a community outbreak.[43] The CDC guidance emphasizes that social distancing is "a cornerstone of reducing transmission of respiratory disease such as

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Strickler, *Nursing Homes Overwhelmed By Coronavirus*, NBC News (Apr. 1, 2020), https://www.nbcnews.com/news/us- news/nursing-homes-overwhelmed-coronavirus-it-impossible-us-stop-spread-n1174171.

[41] *See* Exh. 6 ¶ 10 ("Prisons are congregate environments . . . [s]ocial distancing in ways that are recommended by public health officials can be difficult, if not impossible[.]).

[42] *See generally* I.A. Binswanger et al., *Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population*, 63 J. Epidemiology & Community Health 912 (2009) (concluding that people incarcerated in U.S. jails and prisons had a higher burden of most chronic medical conditions than the general population, even when adjusting for sociodemographic differences and alcohol consumption).

[43] U.S. Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (CDC Guidance) (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

COVID-19."[44] It calls not only for social distancing, but also measures for isolating and quarantining detainees and staff who have (or are suspected of having) COVID-19 from those who do not have (or presumably do not have) the virus.

39. Many correctional facilities find implementation of these preventive strategies challenging without a significant reduction in prison populations.

40. As a general matter, correctional facilities frequently lack sufficient medical supplies for the population, and, in times of crisis, medical staff may cease coming to the facilities. Hot water, soap, and paper towels are often in limited supply. Incarcerated people themselves, rather than professional cleaners, are often responsible for cleaning the facilities and often are not given appropriate supplies. This means there are more people who are susceptible to infection all congregated together in a location where fighting the spread of an infection is nearly impossible.[45]

41. For these reasons, correctional public health experts have recommended the release from custody of people most vulnerable to COVID-19. Exercising authority to enlarge custody to include home confinement or release detainees protects the people with the greatest vulnerability to COVID-19 from transmission of the virus, and it also allows for greater risk mitigation for all people held or working in a prison, jail, or detention center. Release of the most vulnerable people from custody also reduces the burden on the region's health-care infrastructure by reducing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. As Dr. Samra observes: "BOP should take ***immediate steps*** to dramatically downsize the population at Terminal Island, with priority given to those at high risk of harm due to their age and health status and thus are likely to require a disproportionate amount of medical

[44] *Id.*

[45] *See* Exh. 5 ¶ 12.

resources."[46]

42. Courts have responded to this urgent call to reduce incarcerated populations. On March 24, 2020, Presiding Judge Kevin C. Brazile of the Superior Court of California, County of Los Angeles, announced an expedited process for the release of individuals jailed while awaiting trial.[47] By April 13, 2020, the Los Angeles County jail had released 700 individuals.[48] On May 1, 2020, Judge Brazile announced that a further 250 individuals had been released on their own recognizance pursuant to the Court's continued efforts "to protect public safety while achieving social distancing inside . . . the jail system."[49] Between the onset of COVID-19 and May 13, 2020, Los Angeles lowered its county jail population from 17,076 to 11,813, a reduction of 31%.[50] High courts in other states have issued similar orders aimed at reducing state prison populations.[51]

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[46] Exh. 5 ¶ 20.

[47] Los Angeles Superior Court, Superior Court of Los Angeles County Orders Release of County Jail Inmates Awaiting Trial After Justice Partners Reach Agreement (Mar. 24, 2020), http://www.lacourt.org/newsmedia/uploads/142020324174155NR_Justice_Partners_Request_March_24_2020_FINAL.pdf

[48] Los Angeles Superior Court, Superior Court of Los Angeles County Continues to Work With Justice Partners On Jail Release of Adults (Apr. 13, 2020), http://www.lacourt.org/newsmedia/uploads/14202041491026NR_Release_Orders_04_13_20.pdf

[49] Los Angeles Superior Court, More Than 250 People Released So Far From L.A. County Jail System Under Statewide Emergency Bail Schedule (May 1, 2020), http://www.lacourt.org/newsmedia/uploads/14202051114247NR_Bail_Order_05_01_20(003).pdf

[50] Vera Institute of Justice, COVID-19: Criminal Justice Responses to the Coronavirus Pandemic, https://www.vera.org/projects/covid-19-criminal-justice-responses/covid-19-data (last visited May 15, 2020).

[51] *See, e.g.*, *In re: The Petition of the Pennsylvania Prison Society et al.*, No. 70 MM 2020 (Pa. Apr. 3, 2020), *available at* https://law.justia.com/cases/pennsylvania/supreme-court/2020/70- mm-2020.html

43. Officials in California have echoed the calls to release prisoners and facilitate social distancing. On March 31, 2020, the California Department of Corrections and Rehabilitation announced that it would be transitioning nearly 3,500 non-violent inmates to parole or supervised release in order to "mitigate the spread of COVID-19 . . . [and] increase physical distancing, and assist . . . with isolation and quarantine efforts for suspected or positive COVID-19 cases[.]"[52] As of April 13, all of these individuals had been released.[53]

44. Had Respondents similarly reduced the population at Terminal Island as called for by the science, the catastrophe we are faced with today may have been avoided. Because they did not, the outbreak at Terminal Island is now out of control. This not only poses an unacceptable risk to the health and safety of the incarcerated, but also burdens local hospitals and thus endangers the broader community.

(Pennsylvania Supreme Court ordered the chief judge of all counties to "immediately" engage in a review of the "current capabilities of their county correctional institutions . . . to address the spread of COVID-19," "to ensure that the county correctional institutions in their districts address the threat of COVID-19," as necessary "to identify individuals of incarcerated persons for potential release" and "to undertake efforts to limit the introduction of new inmates into the county prison system."); *Comm. for Pub. Counsel Servs. v. Chief Justice of the Trial Court*, No. SJC-12926 (Mass. Apr. 3, 2020), *available at* https://www.mass.gov/files/documents/2020/04/03/12926.pdf (Massachusetts Supreme Court ruled that pre-trial detainees not charged with certain violent offenses, as well as incarcerated individuals held on technical probation and parole violations, is entitled to a rebuttable presumption of release).

[52] California Department of Corrections and Rehabilitation, CDCR Announces Plan to Further Protect Staff and Inmates from the Spread of COVID-19 in State Prisons (Mar. 31, 2020), https://www.cdcr.ca.gov/news/2020/03/31/cdcr-announces-plan-to-further-protect-staff-and-inmates-from-the-spread-of-covid-19-in-state-prisons/

[53] California Department of Corrections and Rehabilitation, Frequently Asked Questions for Plan on Expedited Release and Increased Physical Space Within State Prisons, https://www.cdcr.ca.gov/covid19/frequently-asked-questions-for-plan-on-expedited-release-and-increased-physical-space-within-state-prisons/ (last visited May 15, 2020).

Correctional facilities lack adequate medical facilities to treat serious COVID-19 cases, so an outbreak in a prison could overwhelm local hospitals. And as correctional staff enter and leave the facility, they will carry the virus with them. Like the incarcerated people in the facilities where they work, correctional officers face an increased risk of COVID-19 exposure because they are less able to engage in social distancing and because of the shortage of PPE. Given these dangers, on an accelerating basis since mid-March of this year, courts in this Circuit and across the country have ordered the release of prisoners and detainees in response to the COVID- 19 crisis.[54]

45. When the dangers of COVID-19 have reached a level where a prison is no longer able to incarcerate its population in constitutional conditions, courts have also granted emergency habeas relief for entire classes of prisoners to be evaluated for enlargement of custody on an accelerated basis.[55]

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[54] *See, e.g., Arriaga Reyes. v. Decker*, No. 2:20-cv-03600 (D.N.J. Apr. 12, 2020) (ordering five petitions for immediate release of ICE detainees from New Jersey facilities); *Basank v. Decker*, ---F. Supp.3d---, 2020 WL1481503 (S.D.N.Y. Mar. 26, 2020) (ordering release of ten individuals detained by ICE housed in New Jersey county jails because of preexisting medical conditions); *United States v. Rodriguez*, No. 03-CR-271 (E.D. Pa. Apr. 1, 2020) (granting motion for compassionate release where the presence of COVID-19, the inmate's health conditions, the proximity to his release date, and his demonstration of rehabilitation created extraordinary and compelling reasons justifying release); *United States v. Colvin*, No. 3:19-CR-179, 2020 WL 1613943 (D. Conn. 2020) (waiving exhaustion requirement and granting motion or compassionate release for vulnerable inmate at FDC Philadelphia where "the risks faced by the Defendant will be minimized by her immediate release to home, where she will quarantine herself"); *Coronel v. Decker*, No. 20 Civ. 2472, ---F.Supp.3d---, 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020) (granting release of four detainees with medical conditions that render them particularly vulnerable to severe illness or death if infected by COVID-19).

[55] *Wilson v. Williams*, No. 4:20-CV-00794, 2020 WL 1940882, at *10 (N.D. Ohio Apr. 22, 2020), *appeal filed*, (6th Cir. Apr. 27, 2020) (granting in part emergency motion and ordering FCI Elkton to evaluate all prisoners for enlargement of custody); *Martinez-Brooks v. Easter*, 3-20-cv-00569-MPS, 2020 WL 2405350, at *32

C. Due to Terminal Island's Unique Vulnerability to COVID-19, It Is Not Capable of Adequately Treating Those Infected or Stopping the Spread Without Reducing the Population.

46. Terminal Island's outbreak is the one of the largest of any federal prison, with more infected prisoners than the entire California Department of Corrections and Rehabilitation system combined.[56] The remarkable size and speed of the Terminal Island outbreak is due to the vulnerability caused by a unique combination of three separate aggravating factors: overcrowding, communal living spaces, and vulnerability of the inmate population.

47. First, Terminal Island is severely overcrowded: as of May 15, 2020, 1,042 inmates occupy a prison with a rated capacity of 779.[57] This amounts to an overcrowding rate of 133%, higher than the average federal overcrowding rate of 124%.[58] Even under otherwise ideal conditions, this fact that the prison is already over capacity would render social distancing—a practice that inherently requires that facilities operate at far *under* their usual capacity—extremely difficult if not impossible. Prisons are by nature fertile ground for the spread of COVID-19—

(D. Conn., May 12, 2020) (granting in part temporary restraining order and ordering FCI Danbury to evaluate prisoners with COVID-19 risk factors for home confinement and compassionate release).

[56] *See* Federal Bureau of Prisons, COVID-19 Coronavirus, https://www.bop.gov/coronavirus/ (last accessed May 15, 2020) *compare* California Department of Corrections and Rehabilitation, COVID-19 Preparedness, https://www.cdcr.ca.gov/covid19/ (last accessed May 15, 2020).

[57] Federal Bureau of Prisons, *Prison Rape Elimination Act (PREA) Audit Report*, p. 6 (May 29, 2019), *available at* https://www.bop.gov/locations/institutions/trm/prea_trm.pdf

[58] Department of Justice, FY 2019 Budget Request, p.2, *available at* https://www.justice.gov/jmd/page/file/1033_161/download

overcrowded prisons even more so.[59] In an attempt to mitigate the overcrowding issue, Terminal Island has reportedly moved prisoners to hastily erected tents and converted "rodent-infested, leaky" warehouses into makeshift living spaces.[60] Even with these emergency measures, Terminal Island has failed to ensure adequate social distancing or isolation of infected inmates. To the contrary, the exposure of prisoners to makeshift, unsanitary living spaces merely creates new hot zones for the virus to spread at an even more rapid rate.

48. Second, Terminal Island is a low-security prison, which houses some of least dangerous people in the custody of the federal corrections system. As a result, virtually all of the prisoners at Terminal Island are housed in open dormitory-style settings or cell tiers with communal areas where social distancing is impossible. For instance, Petitioner Lance Wilson lives in Housing Unit F, three tiers of double-occupancy cells containing 150 prisoners.[61] Each of the three tiers has only a single bathroom containing four urinals, four showers, and four sinks for 50 prisoners to share.[62] Prisoners' only excursions out of their cells are to a limited set of communal areas, to retrieve food and pills, to congregate in the television room, and share a single phone.[63] Another petitioner, Maurice Smith, lived in Unit B at the beginning of the outbreak, a typical open dormitory-style housing arrangement, with 60 men cramped in a single room, bereft of barriers to provide any semblance of privacy or

[59] Exh. 5 ¶¶ 12, 14.

[60] Christina Gonzalez, *Terminal Island has nation's worst prison COVID-19 outbreak*, Fox 11 Los Angeles (April 29, 2020), *available at* https://www.foxla.com/news/terminal-island-has-nations-worst-prison-covid-19-outbreak

[61] Exh. 1 ¶ 8.

[62] *Id.*

[63] *Id.*

space from others.[64] Prisoners sleep in long rows, each man two feet from those on either side. Aware of the need to prevent the spread of COVID-19, prisoners have tried to take matters into their own hands by cleaning dormitories, but are limited to watered down disinfectant, dirty mops, and rags cut from blankets.[65]

49. Third, Terminal Island is a Care Level 3 medical facility, designed to "provid[e] specialized or long-term medical or mental health care in a correctional environment."[66] According to BOP guidelines on Care Level classification, "Care Level 3 inmates are outpatients who have complex, and usually chronic, medical or mental health conditions and who require frequent clinical contacts to maintain control or stability of their condition."[67] Many prisoners with underlying conditions that increase vulnerability to COVID-19—including autoimmune conditions, diabetes, blood, heart, lung, kidney, and liver disease—default to Care Level 3.[68] This includes Petitioner Wilson, who has been diagnosed with hypertension, is a long-time asthmatic, and takes medication for, high cholesterol,[69] and Petitioner Smith, who also has hypertension and asthma, and is also pre-diabetic.

50. These people are at Terminal Island precisely because they are the sort of people who are more at risk to COVID-19. Thus, the treatment load created by hundreds of infected prisoners at Terminal Island will be far greater than it would be

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[64] Exhibit 2 ("Exh. 2," Declaration of Jennifer Van Atta) ¶ 5.

[65] Exhibit 3 ("Exh. 3," Declaration of Jackelyn Vasquez) ¶ 7.

[66] Federal Bureau of Prisons, *Prison Rape Elimination Act (PREA) Audit Report*, p. 2 (April 26, 2016), *available at* https://www.bop.gov/locations/institutions/trm/TRM_prea.pdf

[67] Federal Bureau of Prisons, Care Level Classifications Guide (May 2019), p. 6-8, *available at* https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf

[68] *See id.; compare* Exh. 5 ¶ 8.

[69] *Id.*

at an average prison, as more of the infected will require hospitalization and intensive care. This strain on medical resources, in turn, may increase the mortality rate of prisoners infected with COVID-19. Combined with the extraordinarily high infection rate, a high mortality rate would create an exponential threat to the health and safety of Terminal Island's prisoners.[70]

51. In the face of a COVID-19 outbreak, Terminal Island has the worst of all worlds: it is overcrowded enough to make effective social distancing and isolation to be impossible, open and communal enough for inmates to frequently interact in close quarters to spread the disease, while also hosting a uniquely vulnerable inmate population.

D. The Indifference of BOP and Respondents Has Allowed COVID-19 to Spread like Wildfire and Is Putting Inmates at Unconstitutional Risk Daily.

52. As discussed *supra*, Terminal Island has failed to effectively distance or quarantine inmates, and their attempts to do so have merely exposed prisoners to further danger. Terminal Island's preventative failures can be divided into four categories: failure to adequately social distance; failure to provide adequate PPE; failure to adequately test and trace infected persons; and failure to provide constitutionally adequate medical care. Collectively, these failures have led to a devastating number of positive cases and the resulting serious harm and/or death caused in part by an overburdened medical care system.

53. This sad reality is borne out by the information prisoners have relayed to family members and friends despite Terminal Island's best efforts to keep them silenced. Since April 16, 2020, the prison has cut off most communications with the

[70] *See* Exh. 5 ¶ 11 (due to advanced support care required for vulnerable populations, COVID-19 outbreaks can "put significant pressure on or exceed the capacity of local health infrastructure . . . to the extent that the health care infrastructure is overloaded, people will die unnecessarily").

outside world, forcing prisoners to communicate with their loved ones only through letters and, since around May 9, sporadic five-minute phone calls.[71]

54. Counsel for Petitioners have attempted to arrange legal calls with four prisoners incarcerated at FCI Terminal Island who had been identified by their family members and friends as seeking Counsel's representation in this action. Counsel have spoken with only one of them. None of the other calls have been scheduled by the Bureau of Prisons ("BOP").

1. Terminal Island has failed to take measures to create adequate social distance.

55. As discussed *supra*, Terminal Island's communal living spaces make social distancing difficult, if not impossible, without a significant reduction in population. The prison's solution has been to reduce the population density in communal areas by setting up temporary living spaces: some inmates have been placed in field tents, and others in at least one converted warehouse.

56. These temporary spaces have not created adequate social distance. The math is simple: Terminal Island claims that over 200 people, or roughly 20% of the prison population, have been placed in "alternative housing."[72] Terminal Island, however, is already 33% over capacity. The additional space, therefore, does not reduce the overcrowding at Terminal Island even to its rated capacity, much less the substantially reduced capacity necessary for social distancing.

57. Even worse, the deplorable sanitary conditions in the warehouse have simply resulted in trading one hot zone of infection for another. According to Petitioner Maurice Smith, the warehouse is considered so unsanitary that it is

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[71] Exhibit 8 ("Exh. 8," Declaration of Jimmy Threatt) ¶ 2.

[72] Sara Welch, Nouran Salahieh, *More than half of Terminal Island prison inmates test positive for coronavirus, the worst outbreak in federal system*, KTLA 5 (April 29, 2020), *available at* https://ktla.com/news/local-news/terminal-island-prison-sees-worst-coronavirus-outbreak-among-inmates-in-federal-system/

"simply not fit for human habitation."[73] The warehouse is infested by a veritable menagerie: mice, raccoons, wild cats, possums, skunks, and even bats that fly through holes in the ceiling.[74] Prisoners sleep on fold-out lawn beds that are only three feet from the floor, and the warehouse has no drinking water, no hot running water, and no heating—leaving Petitioner Smith to shiver through the night in uncomfortable sleeplessness.[75] Up to 60 prisoners share four toilets, four sinks, and four showers.[76] One could hardly imagine more ideal conditions for a dangerous communicable disease to spread.

2. Terminal Island failed to implement even the most basic preventive measures.

58. Inmates were not provided masks until late April, when in all likelihood COVID-19 had already gained an insurmountable foothold among the population.[77] But even that late attempt was more even more deficient than it seemed at the time, as Terminal Island's promise to distribute new masks once a week quickly slipped to once every two weeks.[78] As such, prisoners have since been forced to re-use masks for extended periods. The shortage of masks is not a problem limited to prisoners: even nurses at Terminal Island regularly complain about the shortage of masks and other personal protective equipment.[79]

59. Even aside from masks, officials have failed to take other simple steps that could be beneficial, such as providing hand sanitizer containing alcohol, hand

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[73] Exh. 2 ¶ 6.

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] Exh. 1 ¶ 12.

[78] *Id.*

[79] Exhibit 4 ("Exh. 4," Declaration of Stephen Rines) ¶ 9.

soap, disinfectants for commonly touched surfaces, and clean clothes. Such measures, while less important than fresh cloth masks, are still recommended by the CDC as effective in preventing the spread of COVID-19.

3. Terminal Island has failed to adequately test, trace, and isolate persons infected by COVID-19.

60. The WHO has called isolation, testing, and tracing "the backbone of response" to coronavirus, and specifically identified these methods as critical to the success of countries such as South Korea.[80] In order to slow the spread within high-risk populations, large numbers of individuals must be tested, those who are positive for COVID-19 must have their contacts must be traced to identify additional individuals who may be infected, and all must be isolated for a period of time. These practices would be extremely difficult to implement in a prison environment even in ideal conditions. At Terminal Island, a failed policy has already rendered conditions far from ideal.

61. Upon information and belief, for weeks after its first positive cases, Terminal Island maintained a policy of testing only symptomatic inmates, despite the fact that COVID-19 can be transmitted by asymptomatic or pre-symptomatic individuals.[81] This policy did not change even after April 15, 2020, when Terminal Island reported its first COVID-19 related death.[82] Terminal Island only begin to test its entire prisoner population on or around April 28, when over half had already

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[80] Linda Lacina, *WHO coronavirus briefing: Isolation, testing and tracing comprise the 'backbone' of response*, World Economic Forum (March 18, 2020), https://www.weforum.org/agenda/2020/03/testing-tracing-backbone-who-coronavirus-wednesdays-briefing/

[81] Exh. 5 ¶ 5.

[82] Prisoner at Terminal Island in San Pedro Dies of Coronavirus, ORANGE COUNTY REGISTER (APRIL 15, 2020), *available at* https://www.dailybreeze.com/2020/04/15/prisoner-at-terminal-island-in-san-pedro-dies-of-coronavirus/

been confirmed as infected.[83] Upon information and belief, aside from that one-time test of the entire population, Terminal Island is even now not regularly testing prisoners who may have been exposed to infected persons, nor is it testing "recovered" COVID-19 patients before they are categorized as such and returned to the general population.

62. As discussed in the preceding paragraphs, Terminal Island has made virtually no effort to legitimately isolate prisoners. Instead, officials have resorted to cohort-style segregation, presumably under the impression that all prisoners in a given group are either positive or negative for COVID-19. For example, in Unit J, where Petitioner Vasquez resides (after the aforementioned period in the warehouse), every prisoner is (purportedly) negative for COVID-19.[84] If a prisoner is determined to have contracted the disease, he is removed from the unit; however, there are no other measures taken to assess whether others that prisoner has been in close contact with have also contracted COVID-19. This situation exposes the fundamental problem with such large-group separation tactics in the face of a highly contagious disease, made all the worse given the facility's failure to implement repeat testing. And much of this segregation occurred before the facility-wide testing, the one-time prisoners received fairly certain indications as to whether or not they had contracted COVID.

63. Even when Terminal Island has not resorted to large cohort-style segregation, it has still failed to implement true quarantines that would help prevent the disease's spread. Stephen Rines, a former inmate at Terminal Island, witnessed groups of three prisoners who had returned from the hospital on different days being

[83] Exh. 1 ¶ 17.

[84] Exh. 3 ¶ 6.

placed together in a single room.[85] This practice continued until April 25, 2020.[86] Mr. Rines also witnessed nurses at Terminal Island complain that there were not enough beds for all prisoners who were suspected of having COVID-19.[87] Their solution was to place symptomatic inmates who had not yet received test results (and thus their diagnoses were not confirmed) in the short stay unit, before returning them to general population, needlessly exposing scores of vulnerable prisoners undergoing medical treatment to the disease.[88]

64. Upon information and belief, the failure of Terminal Island's isolation policy has been so comprehensive that of the nine residential units, there is now only one unit designated as "clean[,]" or reserved for persons who have tested negative for COVID-19. This designation, however, may be illusory: due to the lack of a continuous and consistent testing, tracing, and isolation policy, many of these individuals may have become infected since the testing that occurred in late April.

4. Terminal Island has abdicated its responsibility to provide adequate medical care.

65. Although Terminal Island is a Care Level 3 facility, its short-stay hospital unit simply does not have the resources to deal with a crisis of this scale. The unit has only nine rooms and about a dozen beds total.[89] Nurses who worked there have said that the hospital simply doesn't have enough beds to treat COVID-19 patients.[90] For the vast majority of the hundreds of prisoners at Terminal Island who have been infected with COVID-19, therefore, no monitoring or

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[85] Exh. 4 ¶ 8.

[86] *Id.*

[87] *Id.*

[88] *Id.* ¶ 10.

[89] Exh. 4 ¶ 6.

[90] Id. ¶ 9.

treatment has been forthcoming.

66. Throughout the entirety of the COVID outbreak at Terminal Island, prisoners have rarely been afforded access to healthcare personnel or medical treatment of any kind. The common refrain from correctional officers is to "hang in there," no matter how serious the symptoms.[91] Even after facility-wide testing revealed that COVID-19 had indeed spread through the ranks of prisoners and staff, there has been no change in the approach of prison staff. For instance, Petitioner Wilson suffers from asthma and hypertension, making him vulnerable to COVID-19, tested positive, and experienced severe symptoms in the form of migraines, body chills, and frequent sweating in his sleep. Despite constant complaints, he has been left to languish in his cell.[92]

67. Indeed, the only thing that apparently prompts a response of any kind from staff is when an inmate's condition deteriorates to the point that emergency hospitalization is required. Even then, delays can ensue. For example, Mr. Rines overheard one nurse complain that a prisoner suspected of having COVID-19 was having difficulty breathing and the oxygen levels in his blood were low.[93] Even though she recommended that he immediately be transferred to the off-site hospital, no action was taken for many hours.[94]

68. Finally, on information and belief, inmates have been deprived medical care for their underlying conditions ever since COVID-19 began spreading like wildfire. In any prison, this would be deeply troubling. But Terminal Island, as discussed *supra*, is a Level 3 Care Facility. In short, it is a facility designated by the BOP specifically to house prisoners with chronic medical conditions. In other

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[91] *See* Exh. 3 ¶ 5; Exh. 2 ¶ 9.

[92] Exh. 1 ¶¶ 3, 21, 22.

[93] Exh. 4 ¶ 10.

[94] *Id.*

words, many of these inmates are in need of regular medical attention, which they have been deprived of while simultaneously being subjected to great danger. And their underlying conditions likewise make them more likely to suffer severe complications should they contract COVID-19.

69. Even in the face of this mounting public health catastrophe, Terminal Island has refused to seriously consider the obvious solution for stopping the spread and reducing the burden on its medical personnel: reducing the inmate population. Terminal Island has refused to exercise the authority it has to release people at high risk from infection, which would protect both those individuals and the others, who would remain at a less-crowded facility where effective social distancing and isolation and access to alternative medical care might be possible.

70. Terminal Island has been under significant political pressure to reduce its population. Senator Kamala Harris has stated that "[w]hat is happening at Terminal Island prison is a public health crisis . . . . DOJ must step in to protect staff and inmates and immediately release certain low-risk offenders."[95] Congresswoman Nanette Barragan has noted that "Prison leadership either had no idea how to protect inmates in their care for this, or they simply did not pay attention. Either of those is completely unacceptable."[96]

71. But despite the public pressure from politicians, Respondents continued to move at a glacial pace. For six days, as the virus continued to run rampant, BOP and Warden Ponce did not respond to Congresswoman Barragan's request for a meeting to discuss the health crisis in Terminal Island. On April 30, 2020, Congresswoman Barragan was finally able to speak to Warden Ponce by telephone

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[95] Kamala Harris (@senkamalaharris), Twitter (Apr. 30, 2020, 3:37 PM), https://twitter.com/senkamalaharris/status/1255989646347075591

[96] Miriam Hernandez, *COVID-19 infects more than half of inmates at Terminal Island prison in San Pedro*, ABC 7 (Apr. 29, 2020) https://abc7.com/terminal-island-prison-coronavirus-covid19-bureau-of-prisons/6138903/

and learned that, despite claims that Terminal Island was practicing social distancing, the people incarcerated remained "in close proximity with each other." On the same call, Warden Ponce told the Congresswoman that she was considering permitting home confinement for only 46 vulnerable individuals, and only a handful of requests had actually been granted.[97]

E. The Efforts of the Bureau of Prisons Are Inadequate.

72. The BOP has failed to respond effectively to the COVID-19 pandemic. The BOP failed to anticipate and prepare for the magnitude of the threat that COVID-19 poses to its own staff and the people it detains; it then failed to respond in any meaningful way to initial signs of uncontrolled outbreaks at several of its facilities across the country, including Terminal Island; and it has continued to fail to implement even the baseline measures that would assure the safety of its own staff, of Petitioners and their fellow class members and others incarcerated by the BOP, and of the communities into which staff and others travel on a daily basis.

73. The BOP's preparations were inadequate from the start. The BOP did not issue initial guidance until March 9, and even then addressed only the possibility of telework for some employees at an agency where the vast majority of workers must physically appear at facilities to do their jobs, and mentioned restrictions only for people who had traveled to already-impacted countries.[98]

74. Moreover, the BOP did not make any changes to protocols that call for prisoners to purchase their own cleaning supplies from commissary—preventing many indigent and poor prisoners from being able to buy those supplies—and for

[97] Em Nguyen, *Rep. Barragan Dissatisfied With Terminal Island Federal Prison Warden's Explanation*, Spectrum News 1 (May 1, 2020), https://spectrumnews1.com/ca/la-west/politics/2020/05/01/barragan-dissatisfied-with-terminal-island-federal-prison-warden-s-explanation

[98] *See* Federal Bureau of Prisons, *Memorandum for All Staff* (Mar. 9, 2020), *available at* https://cdn.govexec.com/media/gbc/docs/pdfs_edit/031020cb.pdf.

them to maintain responsibility for cleaning and sanitizing their spaces (whether they have supplies or not).[99]

75. In fact, as late as March 26—weeks after many cities and states had closed restaurants and non-essential businesses, restricted travel, and ordered people to shelter in place— the BOP Director announced that the BOP had merely taken an inventory of soap, rather than taken steps to distribute it at no cost or even at a reduced cost.[100]

76. Among other failures that contributed to spread at BOP facilities, officers reported that even as of late March, they were given only gloves—not masks, face shields, or other PPE— when interacting with prisoners sick enough to require transport to the hospital.[101] Those same officers were ordered back to the job in defiance of CDC guidance that called for self-isolation by correctional staff who had been exposed.[102]

77. Unicor, an entity that runs prisoner work programs for the BOP, continued operating throughout the pandemic and did not began distributing masks

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[99] *See, e.g., Inmate Information Handbook, Federal Bureau of Prisons FCI Elkton, Ohio* at 9, Bureau of Prisons (2012), https://www.bop.gov/locations/institutions/elk/ELK_aohandbook.pdf.

[100] That day the BOP Director issued a statement that "all cleaning, sanitation, and medical supplies have been inventoried. Ample supplies are on hand and ready to be distributed or moved to any facility as deemed necessary." Fed. Bureau of Prisons, *Statement from BOP Director* (Mar. 26, 2020), *available at* https://www.bop.gov/resources/news/20200326_statement_from_director.jsp.

[101] Joseph Neff & Keri Blakinger, *Federal Prisons Agency "Put Staff in Harm's Way" of Coronavirus: Orders at Oakdale in Louisiana Help Explain COVID-19 Spread*, The Marshall Project (Apr. 3, 2020), https://www.themarshallproject.org/2020/04/03/federal-prisons-agency- put-staff-in-harm-s-way-of-coronavirus.

[102] *Id.*

to prisoner workers and correctional officers until about April 2, 2020.[103]

78. Across facilities, the BOP has been "scrambling" to address staffing and resource needs. Despite this, the BOP has continued to limit the number of contractors who can supply PPE, does not have enough tests, and has been sued by its own staff for requiring them to work in hazardous working conditions.[104] The BOP has repeatedly understated the scope of the problem and refused to take steps to assess the situation transparently. For example, the BOP has been artificially reducing their number of reported positive cases by classifying individuals who previously tested positive for COVID-19 but no longer showing symptoms as "recovered" and removing them from the count of positive cases, without re-testing them to confirm that the virus is no longer present in their bodies.[105]

79. BOP's under-reporting of the outbreak at FCI Elkton provides another stark example of their lack of transparency. As of April 6, the BOP had reported eight prisoners and one staff had tested positive at FCI Elkton.[106] Press accounts, however, reported that medical staffing had fallen to fifty percent of capacity, and that three prisoners had already died as of April 6.[107] The full scope of the problem

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[103] Cary Aspinwall, Keri Blakinger, & Joseph Neff, *Federal Prison Factories Kept Running as Coronavirus Spread*, The Marshall Project (Apr. 10, 2020), https://www.themarshallproject.org/2020/04/10/federal-prison-factories-kept-running-as- coronavirus-spread.

[104] Luke Barr, *Federal Prisons Facing Shortages of Resources Amid Coronavirus Outbreak*, ABC News (Apr. 1, 2020), https://abcnews.go.com/Health/federal-prisons-facing-shortages-resources- amid-coronavirus-outbreak/story?id=69920966.

[105] A "problematic" practice according to Dr. Samra. *See* Exh. 5 ¶ 16, 25.

[106] *Id.*

[107] *Ohio Gov. Mike DeWine Authorized Ohio National Guard to Assist Elkton Prison*, WKYC (Apr. 6, 2020), https://www.wkyc.com/article/news/health/coronavirus/ohio-gov-mike-dewine-authorizes-ohio-national-guard-to-assist-elkton-prison/95-d620f3c6-c560-486f-9eac- ebce7c09d4e7.

did not become clear until a federal judge ordered the facility to increase testing, after the BOP admitted that it only had 55 tests on hand for a facility of more than 2,400 prisoners.[108]

80. Conditions had already deteriorated so thoroughly that Ohio Governor Mike DeWine called in the state's National Guard to FCI Elkton, a federal prison.[109] At the press conference announcing that decision, Governor DeWine called on the BOP to stop sending new prisoners to Elkton.[110] And the accuracy of the BOP's reporting of COVID-19 cases in Elkton is in doubt.[111]

81. Ultimately, the U.S. District Court for the Northern District of Ohio ordered enlargement of custody for medically vulnerable prisoners at FCI Elkton pending resolution of a class habeas petition on the merits, because of the outbreak

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[108] *Judge grills federal prisons lawyer on lack of coronavirus tests at Ohio facility in wake of Trump's claim that 'anybody' can get tested*, Cleveland.com (Apr. 18, 2020), https://www.cleveland.com/court-justice/2020/04/judge-grills-federal-prisons-lawyer-on-lack-of-coronavirus-tests-at-ohio-facility-in-wake-of-trumps-claim-that-anybody-can-get-tested.html.

[109] Ohio Gov. Mike DeWine Authorized Ohio National Guard to Assist Elkton Prison, WKYC (Apr. 6, 2020), https://www.wkyc.com/article/news/health/coronavirus/ohio-gov-mike-dewine-authorizes-ohio-national-guard-to-assist-elkton-prison/95-d620f3c6-c560-486f-9eac-ebce7c09d4e7.

[110] Cory Shaffer, *Ohio National Guard Will Assist With Response at Elkton Federal Prison*, Cleveland.com (Apr. 6, 2020), https://www.cleveland.com/coronavirus/2020/04/ohio-national-guard-will-assist-with-coronavirus-response-at-elkton-federal-prison.html; *see also* Brandon Brown, *Sen. Portman Urges Prisoners Not to be Transferred to FCI Elkton*, WFMJ (Apr. 6, 2020), https://www.wfmj.com/story/41979544/sen-portman-urges-prisoners-not-be-transferred-to-fci-elkton.

[111] *Elkton Union President Reports Different COVID-19 Stats Than Federal Bureau of Prisons*, WKVB (Apr. 9, 2020), https://www.wkbn.com/news/coronavirus/elkton-union-president-reports-different-covid-19-stats-than-federal-bureau-of-prisons/.

already raging at the facility.[112]

82. Such conditions at numerous facilities across the country have led BOP employees including corrections officers to file a complaint with the Occupational Safety and Health Administration (OSHA) alleging unsafe conditions at numerous federal prisons nationwide, including Terminal Island. Among other things, the officers' OSHA complaint points to the BOP having "directed staff through the Bureau of Prisons who have come in contact with, or been in close proximity to, prisoners who show or have shown symptoms of COVID-19, to report to work and not be self-quarantined for 14 days per the CDC guidelines." It also complains of the BOP having failed to undertake any workplace or administrative controls to address transmission, to require social distancing or other measures in the CDC guidance, or to provide sufficient PPE.[113]

83. In apparent response, the BOP released a short document titled "Correcting Myths and Misinformation about BOP and COVID-19."[114] In attempting to rebut the assertion that staff who had been in contact with prisoners who showed symptoms of COVID-19 still had to come to work, the BOP simply confirmed that such employees *were* required to come to work, with masks.[115]

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[112] *Wilson v. Williams*, No. 4:20-CV-00794, 2020 WL 1940882, at *10 (N.D. Ohio Apr. 22, 2020).

[113] *See* Notice of Alleged Safety or Health Hazards (March 31, 2020), *available at* https://www.afge.org/globalassets/documents/generalreports/coronavirus/4/osha-7-form-national-complaint.pdf

[114] See Fed. Bureau of Prisons, Correcting Myths and Misinformation About BOP And COVID-19 (Apr. 11, 2020), https://www.bop.gov/coronavirus/docs/correcting_myths_and_misinformation_bop_covid19.pdf

[115] *Id.* at 3 ("In keeping with CDC 'Guidance for Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19,' the BOP performs pre-screening of all employees reporting to work and requires exposed workers to wear a mask for 14 days after last

84. The CARES Act, signed into law on March 27, makes funding available for federal prisons to purchase PPE and test kits for COVID-19 in addition to authorizing the Department of Justice to lengthen the maximum amount of time that a prisoner can be placed in home confinement during the pandemic, as discussed above.[116] Acting under that authority, Attorney General Barr made a finding that emergency conditions are materially affecting the functioning of the BOP, and on April 3 he directed Respondent Carvajal to review prisoners with COVID-19 risk factors to determine their eligibility for home confinement, stating that the BOP's efforts to prevent COVID-19 from entering BOP facilities and infecting prisoners have "not been perfectly successful at all institutions."[117]

85. Attorney General Barr also released guidance in the form of a series of letters suggesting that some BOP prisoners should be released.[118] Those letters merely encourage the BOP to exercise discretion that it has declined to use, and they do not actually direct the release of categories of prisoners, much less on a scale that would allow for safe social distancing in the facilities or with the speed that the health crisis requires. Of the relatively small number of people released, the BOP has not reported the number who subsequently died.

86. On April 22, the BOP issued a memo purporting to interpret Attorney General Barr's guidance, substantially limiting the number and types of people who

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exposure. They are also expected to perform regular self-monitoring for symptoms, practice social distancing and to disinfect and clean their work spaces. Anyone who develops signs or symptoms of illness are sent home.").

[116] CARES Act, Pub. L. No. 116-136, § 12003(b), 134 Stat. 281 (2020).

[117] Memorandum from Attorney General Barr to Director Carvajal (Apr. 3, 2020), *available at* https://www.justice.gov/file/1266661/download

[118] *See* Mar. 26, 2020 and Apr. 3, 2020 Memoranda For Director of Bureau Prisons from Attorney General Barr, *available at* https://www.justice.gov/coronavirus

might qualify for home confinement under the Attorney General's memos.[119] Even though the April 3 Barr memo directed the BOP to "immediately maximize appropriate transfers to home confinement," including prioritizing those at "outbreak prisons," the BOP's own guidance excludes the vast majority of prisoners in its custody by adding a number of barriers to consideration for release.

87. The BOP's April 22 guidance gave wardens virtually unchecked discretion to deny a request for release and imposes unnecessary and arbitrary barriers on prisoners seeking release. For example, pursuant to the BOP's guidance from April 22: (i) prisoners must have had no disciplinary infractions of any kind for 12 months; (ii) prisoners must provide verification that they would have a lower risk of contracting COVID-19 outside the prison than inside of it, and, (iii) prisoners with any on-going medical care must show their medical needs can be met outside the prison, and that they have a 90-day supply of prescribed medications. After reports of positive cases continued to explode, on May 8, 2020, BOP amended this guidance to relax a few criteria, but it continues to be far more restrictive than the recommendations proposed by Attorney General Barr.

88. The appalling conditions of BOP facilities across the country, and the BOP's failures to address the constitutional rights of prisoners in its care, have forced federal courts to address BOP failures in a large number of individual cases

[119] Memorandum from Correctional Programs Division Acting Assistant Director Andre Matevousian & Reentry Services Division Assistant Director Hugh J. Hurwitz to Chief Executive Officers (Apr. 22, 2020), *available at* https://famm.org/wp-content/uploads/bop-memo-4.23.2020.pdf

seeking compassionate release[120]; bail pending appeal, trial, or sentencing[121]; delayed self-surrender[122]; writs of habeas corpus[123]; class-wide relief for groups of prisoners[124]; and furloughs.[125]

89. As noted, the Northern District of Ohio ordered FCI Elkton to release potentially hundreds of medically vulnerable prisoners who face a greater threat from COVID-19. It did this because Elkton had "altogether failed" to follow CDC

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[120] *E.g.*, *United States v. Smith*, No. 12-cr-133, 2020 WL 1849748 (S.D.N.Y. Apr. 13, 2020) (granting release; finding exhaustion waivable and waived); *United States v. Zukerman*, ---F.Supp.3d ---, 2020 WL1659880 (S.D.N.Y. Apr. 3, 2020) (waiving exhaustion and granting immediate compassionate release in light of COVID-19 to defendant convicted in multi-million dollar fraud scheme); *United States v. Sawicz*, No. 08-cr-287, 2020 WL1815851 (E.D.N.Y. Apr. 10, 2020) (releasing child-pornography offender); *United States v. Oreste*, No. 14-cr-20349 (S.D. Fla. Apr. 6, 2020).

[121] *E.g.*, *United States v. Chavol*, No. 20-50075 (9th Cir. Apr. 2, 2020) (stipulation in a FRAP(9) appeal to release on conditions); *United States v. Hector*, No. 2:18-cr-3-2, ECF 748 (W.D. Va. Mar. 27, 2020).

[122] *United States v. Roeder*, No. 20-1682, ___ F. App'x ___, 2020 WL 1545872 (3d Cir. Apr. 1, 2020) (reversing district court's denial of defendant's motion to delay execution of his sentence because of the COVID-19 pandemic); *United States v. Garlock*, No. 18-CR-418, 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020) (observing that "[b]y now it almost goes without saying that we should not be adding to the prison population during the COVID-19 pandemic if it can be avoided"); *United States v. Matthaei*, No. 19-CV-243, 2020 WL 1443227, at *1 (D. Idaho Mar. 16, 2020) (extending self-surrender date by 90 days in light of pandemic).

[123] *E.g.*, *Xochihua-Jaimes v. Barr*, No. 18-71460, 798 F. App'x 52 (9th Cir. Mar. 23, 2020) (Mem) (*sua sponte* releasing detainee from immigration detention "in light of the rapidly escalating public health crisis"); *Fraihat v. Wolf*, No. 5:20-CV-590 (C.D. Cal. Mar. 30, 2020).

[124] *E.g.*, *In re Request to Commute or Suspend County Jail Sentences*, Docket No. 084230 (N.J. Mar. 22, 2020) (releasing large class of defendants serving time in county jail "in light of the Public Health Emergency" caused by COVID-19).

[125] *E.g.*, *United States v. Stahl*, No. 18-cr-694, 2020 WL 1819986 (S.D.N.Y. Apr. 10, 2020).

guidance for correctional settings, and that the measures were "necessary to stop the spread of the virus and save lives."[126] Similarly, the District of Connecticut has ordered FCI Danbury to evaluate and release medically vulnerable inmates on an accelerated basis.[127]

V.

LEGAL GROUNDS FOR PETITION

A. Respondents' Failure to Take Steps to Mitigate Transmission of COVID-19 Constitutes Deliberate Indifference to the Serious Medical Needs of Petitioner.

90. Respondents are violating Petitioners' Eighth Amendment rights by continuing to incarcerate them in conditions that place them at substantial risk of serious harm from transmission of an infectious and deadly disease, especially considering Petitioners' vulnerable conditions.

91. All individuals held at Terminal Island have been convicted and assigned by the BOP to serve time at Terminal Island. Therefore, the treatment of all individuals incarcerated at Terminal Island, including the treatment of Petitioners, is governed by the Eighth Amendment. *See Wilhelm v. Rotman*, 680 F.3d 1113, 1122 (9th Cir. 2012). The Ninth Circuit employs a two-part test in assessing whether prison officials have violated the Eighth Amendment by way of deliberately indifference to the medical needs of inmates: (1) the plaintiff must have "a serious medical need by demonstrating that failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain"; and (2) the defendants' "response to the need" must have been "deliberately indifferent." *Id.*

92. Government officials act with deliberate indifference when they

[126] *Wilson*, 2020 WL 1940882, at *8.

[127] *Martinez-Brooks*, 2020 WL 2405350, at *32.

"ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year," even when "the complaining inmate shows no serious current symptoms." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). This Court need not "await a tragic event" to find that Respondents are maintaining unconstitutional conditions of confinement. *Id.* at 32–33. This is so not only because a tragedy is ongoing, but because even petitioners and class members who have not yet tested positive have a constitutional right to be free from conditions of confinement that "pose an unreasonable risk of serious damage to [Petitioner's] future health." *Id.* at 35.

93. Indeed, the threat of exposure to a deadly infectious disease such as COVID-19 and subsequent mistreatment due to lack of resources constitutes a serious risk to health, particularly for the Petitioners because of their unique vulnerability to COVID-19. *See Helling*, 509 U.S. at 34 (noting with approval Eighth Amendment claims based on exposure to serious contagious diseases); *Unknown Parties v. Johnson*, No. cv-15-00250, 2016 WL 8188563, at *15 (D. Ariz. Nov. 18, 2016), aff'd sub nom *Doe v. Kelly*, 878 F.3d 710 (finding evidence of medical risks associated with . . .being exposed to communicable diseases" adequate to establish irreparable harm under the Eighth Amendment); *Castillo v. Barr*, --- F. Supp. 3d ---, 2020 WL 1502864, at *5 (C.D. Cal. Mar. 27, 2020) (in civil detainment context, ruling that officials could not "be deliberately indifferent to the potential exposure of civil detainees to a serious, communicable disease on the ground that the complaining detainee shows no serious current symptoms, or ignore a condition of confinement that is more than very likely to cause a serious illness").

94. As such, Petitioners are entitled to be protected from conditions of confinement that create a serious risk to health or safety, including through release from custody when necessary. *Brown v. Plata*, 563 U.S. 493, 531–32 (2011) (upholding lower court's order releasing people from state prison even though release was based on prospect of future harm caused by prison overcrowding); *see*

also Farmer v. Brennan, 511 U.S. 825, 834 (1994) (correctional official violates Eighth Amendment by consciously failing to prevent "a substantial risk of serious harm").

95. Under Terminal Island's current conditions, Respondents have not and cannot protect Petitioners and the class from this well-known risk of serious harm. In these circumstances, enlargement of custody and, if necessary, release, is required to protect Petitioners and other prisoners with high- risk health conditions from unconstitutional custody.

96. In this case, as established by the facts above, Petitioners face a significant risk of exposure to COVID-19, with the attendant risk of death that follows given their vulnerable conditions. Respondents are well aware of this risk, having been alerted to it by the CDC, the Attorney General, BOP guidance, widespread news reporting, and the ongoing outbreak at various BOP facilities including Terminal Island itself. Indeed, the Second Circuit Court of Appeals, unprompted, acknowledged over a month ago the "grave and enduring" risk posed by COVID-19 in the correctional context. *Fed. Defs. of New York, Inc. v. Fed. Bureau of Prisons*, No. 19-1778, -- F.3d --, 2020 WL 1320886, at *12 (2d Cir. Mar. 20, 2020).

97. Finally, as established above, Respondents have not taken steps sufficient to protect Petitioners from the grave risks that are present every moment he is incarcerated at Terminal Island. Respondent Ponce has recklessly failed to follow or implement CDC guidance or directives from Attorney General Barr or the BOP. Respondents are not capable of managing the risk to Petitioners in the facility's current environment. Respondents are holding Petitioners in violation of their Eighth Amendment rights by detaining them in the face of significant threats to his health and safety without taking reasonable steps to prevent or address that harm.

B. Overcrowding Ensures That Respondents Cannot Implement Recommended Measures Required to Protect Petitioner's Health, and Violates the Eighth Amendment.

98. Respondents are violating Petitioners' Eighth Amendment rights by continuing to incarcerate them in conditions that place them at substantial risk of serious harm from transmission of an infectious and deadly disease.

99. As alleged above, the BOP has thus far failed to implement effective social distancing across its facilities, including and particularly at Terminal Island, with disastrous effects. Part of this failure reflects the nature of correctional confinement; however, a large part here owes to the particular circumstances of Terminal Island's design, capacity, and deliberate choices about policies by Respondents.

100. Respondents have chosen to overcrowd Terminal Island in the midst of a global pandemic at a rate of 133% capacity. The profound and purposeful overcrowding Terminal Island ensures that effective social distancing is impossible, and it stymies Respondents' ability to follow and implement the CDC Interim Guidance and other viral-transmission prevention measures.

101. Courts have long found that facilities' populations may exacerbate existing harms entirely unrelated to the fact of crowding itself, including cases where overcrowding may inhibit a facility's ability to mitigate incarcerated individuals' risk of contracting dangerous diseases. The Supreme Court itself has recognized that correctional defendants such as Respondents can violate the Eighth Amendment when they crowd prisoners into shared spaces with others who have "infectious maladies." *Helling v. McKinney*, 509 U.S. 25, 33 (1993); *see also Hutto v. Finney*, 437 U.S. 678, 682–85 (1978) (recognizing the need for a remedy where prisoners were crowded into cells and some had infectious diseases).

102. Such decisions make particular sense in light of substantial corroborating evidence that transmission becomes more likely in light of, among

other factors, relative crowding of people together. *See*, *e.g.*, Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 Clinical Infectious Diseases 1047, 1047 (Oct. 2007) ("The probability of transmission of potentially pathogenic organisms is increased [in jails and prisons] by crowding, delays in medical evaluation and treatment, rationed access to soap, water, and clean laundry, [and] insufficient infection-control expertise."), *available at* https://bit.ly/2QZA494.

103. In this case, Petitioners face an elevated risk of serious illness both because of particular failures on the part of Respondents as alleged above, and because Respondents have chosen to overcrowd the facility. The current population of Terminal Island, both of incarcerated individuals and the staff who come through on a daily basis and work in the same confined space, ensures that any effective measures that would mitigate Petitioner's exposure to and risk of serious illness from COVID-19 are impossible to implement.

VI.

CLASS ACTION ALLEGATIONS

104. Petitioners bring this action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure on their own behalf and on behalf of all persons similarly situated.

105. Petitioners seek to represent a class consisting of all current and future people in post-conviction custody at Terminal Island (the "Class")[128]

106. The members of both the Class are too numerous to be joined in one action, and their joinder is impracticable. Upon information and belief, the Class exceeds 1,000 individuals.

107. Several common questions of law and fact apply to all Class members. These common questions of fact and law include but are not limited to: (1) whether the conditions of confinement described in this Petition amount to constitutional

[128] *See* Exh. 5 ¶ 8.

violations; (2) what measures Respondents have taken and are taking in response to the COVID-19 crisis; (3) whether Respondents have implemented and are implementing an adequate emergency plan during the COVID-19 crisis; (4) whether Respondents' practices during the COVID-19 crisis have exposed and are exposing prisoners at Terminal Island to a substantial risk of serious harm; (5) whether the Respondents have known of and disregarded a substantial risk of serious harm to the safety and health of the Class; and (6) what relief should be awarded to redress the harms suffered by members of the Class as a result of the conditions.

108. Absent class certification, individuals incarcerated at Terminal Island during the COVID- 19 pandemic would face a series of barriers in accessing the relief sought. Terminal Island has suspended visitation, and individuals incarcerated there have limited access to communication with the outside world, impeding their ability to obtain legal representation and pursue litigation. Because the Class are all sentenced prisoners, they do not have defense attorneys already working with them on their criminal proceedings. And a large portion of the Class has limited educational backgrounds and financial means.

109. Respondents' practices and the claims alleged in this Petition are common to all members of the Class.

110. The claims of Petitioners are typical of those of the Class. Petitioners, like all others at Terminal Island, are currently being held in unconstitutional custody at Terminal Island. Petitioners Wilson and Smith, like many members of the Class, have underlying conditions that enhance their risk of serious illness or death from COVID-19. The legal theories on which Petitioners rely are the same or similar to those on which all Class members would rely, and the harms suffered by them are typical of those suffered by all the other Class members.

111. The legal theories on which Petitioners rely are the same or similar to those on which all Class members would rely, and the harms suffered by them are typical of those suffered by all the other Class members.

112. Petitioners will fairly and adequately protect the interests of the Class. The interests of the Class representatives are consistent with those of the Class members. In addition, counsel for Petitioners are experienced in class action and civil rights litigation and in criminal law.

113. Counsel for Petitioners knows of no conflicts of interest among Class members or between the attorneys and Class members that would affect this litigation.

VII.

CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

(Eighth Amendment)

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

28 U.S.C. § 2241/28 U.S.C. § 2243

Class versus All Defendants

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

115. Petitioners bring this claim on their own behalf and on behalf of the Class.

116. The Eighth Amendment guarantees sentenced prisoners custody free of "a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Helling*, 509 U.S. at 33; *see also* U.S. Const. Amend VIII. The government's failure to protect the prisoners in its custody from a widespread outbreak of a serious contagious disease that causes potentially permanent damage or death constitutes deliberate indifference in violation of the Eighth Amendment to the United States Constitution.

117. Petitioners and the Class are at severe risk of contracting COVID-19 because 60% of inmates have already tested positive. Petitioners and many members

of the Class are uniquely vulnerable to serious complications or death from contracting COVID-19 because of their age and/or because they suffer from medical conditions that render them uniquely vulnerable.

118. Because of the conditions at Terminal Island, Petitioners and Class members cannot take steps to protect themselves—such as social distancing, hand-washing hygiene, or self-quarantining—and the government has not provided adequate protections. As COVID-19 rapidly spreads inside Terminal Island, the already deplorable conditions at the prison will continue to deteriorate, and incarcerated individuals there will continue to contract COVID-19 at staggering rates. Due to inadequate medical care at Terminal Island, the health and safety of those who contract COVID-19 will be put in unconstitutional danger.

119. Petitioners contend that the fact of their confinement in prison itself amounts to an Eighth Amendment violation under these circumstances, and nothing short of an order ending their confinement at Terminal Island will alleviate that violation.

120. Respondent's failure to adequately protect Petitioners from these unconstitutional conditions, or release them from the conditions altogether, constitutes deliberate indifference to a substantial risk of serious harm to Petitioners, and all members of the Class, thereby establishing a violation of the Eighth Amendment to the United States Constitution.

121. Respondents were aware or should have been aware of these conditions, which were and are open and obvious throughout the entire prison

122. Respondents knew of and disregarded an excessive risk to health and safety.

123. Respondents failed to act with reasonable care to mitigate these risks, subjecting Petitioners to a grave and serious risk of harm of serious illness, permanent injury, or death.

124. Because Respondents failed to act to remedy Petitioners' and the

Class's degrading and inhumane conditions of confinement in violation of their Eighth Amendment rights, Petitioners seek relief under this Writ of Habeas Corpus Petition and Class Action Complaint.

125. Because of the unlawful conduct of Respondents, Petitioners and the Class are threatened with imminent physical injury, pain and suffering, emotional distress, humiliation, and death.

SECOND CLAIM FOR RELIEF

(Eighth Amendment)

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

Injunctive Relief Only

U.S. Const. Amend. VIII; 28 U.S.C. § 1331; 5 U.S.C. § 702

Class versus All Defendants in their Official Capacities

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

127. Petitioners bring this claim on their own behalf and on behalf of the Class.

128. This claim does not seek the release of any members of the Class and accordingly is not maintained pursuant to 28 U.S.C. § 2241. However, it is well-established that individuals may sue to enjoin constitutional violations, either directly under the Constitution or under the Administrative Procedure Act. *See Sierra Club v. Trump*, 929 F.3d 670, 694 (9th Cir. 2019) ("Plaintiffs may bring their challenge through an equitable action to enjoin unconstitutional official conduct, or under the judicial review provisions of the Administrative Procedure Act ("APA"), 5 U.S.C. § 701 *et seq.*, as a challenge to a final agency decision that is alleged to violate the Constitution, or both."); *Fazaga v. FBI*, 916 F.3d 1202, 1239-1241 (9th Cir. 2019) (permitting claims against federal officials in their official capacities for injunctive relief directly under the Fourth Amendment, even though

Privacy Act provides for other remedies, and contrasting them to direct actions under the Fourth Amendment for money damages, which are *Bivens* claims); *Jones v. Hurwitz*, 324 F. Supp. 3d 97, 100 (D.D.C. 2018) (finding that a *Bivens* claim could not be maintained because allegations were against defendants in their official capacities but that equitable action could have been maintained as a "direct cause of action arising under the Constitution"); *Farmer v. Brennan*, 511 U.S. 825, 846 (1994) ("If the court finds the Eighth Amendment's subjective and objective requirements satisfied" with regard to a federal prisoner, "it may grant appropriate injunctive relief.").

129. Because of the conditions at Terminal Island, Petitioners and Class members cannot take steps to protect themselves—such as social distancing, hand-washing hygiene, or self-quarantining—and the government has not provided adequate protections. As COVID-19 rapidly spreads inside Terminal Island, the already deplorable conditions at the prison will continue to deteriorate, and incarcerated individuals there will continue to contract COVID-19 at staggering rates.

130. Respondent's failure to adequately protect Petitioners from these unconstitutional conditions, or release them from the conditions altogether, constitutes deliberate indifference to a substantial risk of serious harm to Petitioners, and all members of the Class, thereby establishing a violation of the Eighth Amendment to the United States Constitution.

131. Because of the unlawful conduct of Respondents, Petitioners and the Class are threatened with imminent physical injury, pain and suffering, emotional distress, humiliation, and death.

VIII.

RELIEF REQUESTED

WHEREFORE, Petitioners and the Class, respectfully request that the Court:

1. Declare that Terminal Island's custody of Petitioners and the Class

violates the Eighth Amendment right against cruel and unusual punishment with respect to Petitioners and the Class;

2. Order a highly expedited process—for completion within no more than 48 hours—for Respondents to use procedures available under the law to review members of the Class for enlargement of custody to home confinement (or bail pending habeas corpus) in order to reduce the density of the prison population to a number that allows for the implementation of appropriate measures to prevent the spread of COVID-19, during the pendency of this petition for a writ of habeas corpus;

3. Order respondents to comply with the Constitution for any Class members who do not receive temporary enlargement and remain at Terminal Island during the pendency of the petition;

4. Grant a writ of habeas corpus for all members of the class that received temporary enlargement within one day of the Court's order and release all such persons within twenty-four hours;

5. Enter a temporary restraining order, preliminary injunction and permanent injunction requiring Respondents to immediately adopt mitigation efforts to protect all Class Members not released, including but not limited to:

A. Providing adequate spacing of six feet or more between incarcerated people so that social distancing can be accomplished in accordance with CDC guidelines;

B. Ensuring that each incarcerated person receives, free of charge, an individual supply of hand soap and paper towels sufficient to allow frequent hand washing and drying each day; an adequate supply of clean implements for cleaning such as sponges and brushes and disinfectant hand wipes or disinfectant products effective against the virus that causes COVID-19 for daily cleanings;

C. Ensuring that all incarcerated people have access to hand sanitizer containing at least 60% alcohol;

D. Providing access to daily showers and daily access to clean laundry, including clean personal towels and washrags after each shower;

E. Requiring that all Terminal Island staff wear personal protective equipment, consistent with the CDC guidance, including masks and gloves, when interacting with any person or when touching surfaces in cells or common areas;

F. Requiring that all Terminal Island staff wash their hands, apply hand sanitizer containing at least 60% alcohol, or change their gloves both before and after interacting with any person or touching surfaces in cells or common areas;

G. Taking the temperature of all class members and screening for symptoms of COVID-19 of all class members, prison staff, and visitors daily (with a functioning and properly operated and sanitized thermometer) to identify potential COVID-19 infections;

H. Assessing (through questioning) each incarcerated person daily to identify potential COVID-19 infections;

I. Ensuring that all class member and prison staff exposed to individuals with known cases of COVID-19 be isolated from individuals who have not tested positive.

J. Immediately providing on a daily basis clean masks for all individuals who display or report potential COVID-19 symptoms until they can be evaluated by a qualified medical professional or placed in non-punitive quarantine and ensure the masks are properly laundered with replacements as necessary;

K. Ensuring that individuals identified as having COVID-19 or having been exposed to COVID-19 receive adequate medical care and are properly quarantined (without resorting to cohorting, if possible), in a non-punitive setting, with continued access to showers, recreation, mental health services, reading materials, phone and video visitation with loved ones, communications with counsel, and personal property;

L. Cleaning and disinfecting frequently touched surfaces with disinfectant products effective against the virus that causes COVID-19 (at the manufacturer's recommended concentration), as well as surfaces in common areas, every two hours during waking hours, and at least once during the night;

M. Assuring incarcerated people are told they will not be retaliated against for reported COVID-19 symptoms;

N. Providing necessary medical treatment consistent with community standards for incarcerated people who are ill because of COVID-19;

O. Responding to all emergency (as defined by the medical community) requests for medical attention within an hour;

P. Crafting a mechanism to ensure compliance through the appointment of an independent monitor with medical expertise to ensure compliance with these conditions, and provide the monitor with unfettered access to medical units, confidential communication with detained individuals in and out of quarantine, and surveillance video of public areas of the facilities.

6. Certify this petition as a class action, for the reasons stated herein;

7. Award Plaintiffs' attorneys' fees and costs, as provided by statute and

law; and

8. Order such other and further relief as this Court deems just, proper and equitable.

Local Rule 5-4.3.4(a)(2)(i) Compliance: Filer attests that all other signatories listed concur in the filing's content and have authorized this filing.

DATED: May 16, 2020

Respectfully submitted,

Terry W. Bird
Dorothy Wolpert
Naeun Rim
Shoshana E. Bannett
Christopher J. Lee
Jimmy Threatt
Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, P.C.

By: */s/ Naeun Rim*
Naeun Rim
Attorneys for Plaintiff-Petitioners

DATED: May 16, 2020

Peter J. Eliasberg
Peter Bibring
ACLU Foundation of Southern California

By: */s/ Peter Bibring*
Peter Bibring
Attorneys for Plaintiff-Petitioners

DATED: May 16, 2020

Donald Specter
Sara Norman
Prison Law Office

By: */s/ Donald Specter*
Donald Specter
Attorneys for Plaintiff-Petitioners

EXHIBIT 1

DECLARATION OF JACQUE WILSON

I, Jacque Wilson, am over the age of 18 and fully competent to declare as follows:

1. I am a Deputy Public Defender at the San Francisco Public Defender's Office. My California State Bar Number is 214259.

2. My brother is Lance Aaron Wilson. Lance is 35 years old. My brother is currently incarcerated at FCI Terminal Island in San Pedro, California. His BOP Register Number is 72372-097.

3. My brother has lived with asthma for most of his life. While incarcerated, he was also diagnosed with hypertension. Currently, he has been prescribed Lisinopril 20 mg and Hydrochlorothiazide for his hypertension. He has also been prescribed Atorvastatin for his high cholesterol.

4. I am writing this declaration on my brother's behalf because he has had extreme difficulty making phone calls and has not been able to get in direct contact with an attorney. On April 16, 2020, my brother was told that prisoners would not be able to use phones and computers until further notice. From then until May 9, 2020, the only way he has been able to communicate with my father and me has been through letters. I had three five-minute phone calls with my brother on May 9, May 10, and May 14. During our call on May 9, he confirmed to me that he wished to be a party to this lawsuit.

5. Up until May 14, 2020, he was not able to make a legal call to a lawyer since April 16, 2020. I understand that on May 14, 2020, he had a brief legal call with one of the attorneys representing him in this lawsuit.

6. Through calls and letters, my brother has told me about the horrific conditions inside of Terminal Island. I have described them in more detail below, but in short, for weeks, the prison did nothing to protect my brother and other prisoners from catching the virus, and on May 6, 2020, my brother told me he tested positive for COVID-19. Despite having body chills and severe migraines, he has

not been able to see a doctor or get any treatment, and he fears he will be left to die.

7. The following is information passed onto me from my brother through letters and short phone calls. I have confirmed with my brother that this information is correct to the best of his knowledge:

8. My brother currently resides in Housing Unit F ("Unit F") at Terminal Island. Unit F is divided into three floors, known as "tiers," with 50 people on each tier, for a total of 150 people. Everyone in Unit F is housed in a two-person cell, and each cell contains a bunkbed. There is only two feet of space separating the top bunk from the bottom bunk, which are so close that while sleeping on the top bunk, my brother can reach down and touch his cellmate on the bottom bunk.

9. There is only one bathroom on each tier to be shared by all 50 people on that tier. The single bathroom has only four urinals, four showers, and four sinks. One urinal in the bathroom on my brother's tier has been broken for several weeks, so they share three urinals instead of the usual four. Everyone also shares a single TV room and one phone. It is impossible to avoid personal contact in the crowded hallways and shared spaces. Almost everyone in Unit F is sick, and people have been transferring in and out of the unit frequently.

10. For around two weeks, Unit F has had no hot water. Prisoners have been complaining daily about the lack of hot water, but nothing has been done.

11. Meals and medication are given to people housed in Unit F in the unit lobby, and all 150 prisoners have to go to the lobby and stand in line to receive food or medication. My brother says they are often waiting in line for some time before they can pick up food and medication and are not able to practice social distancing while in line.

12. My brother did not receive a mask until about two weeks ago. After that, he was told that they would receive masks every week, but in practice it has been closer to once every two weeks, and my brother and others around him have had to reuse masks. The guards wear masks sometimes, but not always. My brother

has never received any gloves or eyewear, nor does he have access to hand sanitizer.

13. Throughout this time period, prisoners around my brother started getting sick, first one by one and eventually in bunches at a time. My brother was scared that he would become sick himself, and felt like nothing was being done to stop the virus from spreading. He began to write a series of letters to myself and my father to let us know what he was going through.

14. Attached hereto as **Exhibit A** is a true and accurate copy of a letter my brother sent to me on April 18, 2020.

15. Attached hereto as **Exhibit B** is a true and accurate copy of a letter my brother sent to me on April 21, 2020.

16. Attached hereto as **Exhibit C** is a true and accurate copy of a letter my brother sent to me on April 23, 2020.

17. Attached hereto as **Exhibit D** is a true and accurate copy of a letter my brother sent to me on April 28, 2020.

18. Attached hereto as **Exhibit E** is a true and accurate copy of a letter my brother sent to me on April 29, 2020.

19. The final letter my brother sent to me was dated May 6, 2020. A true and accurate copy is attached hereto as **Exhibit F**. In that letter, he told us that he had tested positive for COVID-19.

20. My brother was tested for COVID-19 on April 28, 2020. On May 1, 2020, he was told that his results came out positive. That is the only time he has been tested so far.

21. Since then, my brother has been experiencing symptoms, including migraines, body chills, and frequent sweating in his sleep. He has not been given any medication, any treatment, and nobody is monitoring his status. He has not been able to talk to a doctor about how he is feeling, how bad his symptoms are likely to become, or what his treatment options are.

22. My brother has simply been left in his housing unit with other sick

people, who are not receiving treatment either. New sick people keep arriving in his unit. My brother and others in his unit feel that they have been abandoned and are being left to die.

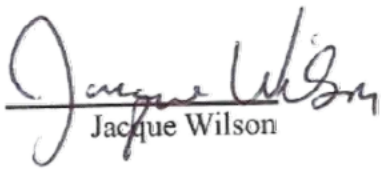
23. Although the prison has attempted to separate prisoners who have tested positive from those who have tested negative, this separation did not take place until five days after prisoners were tested, when the results for everyone had come out. As a result, the virus may have spread to many prisoners who had tested negative in the interim.

24. Since the virus began spreading here, my brother has not been permitted to submit complaints to staff. Staff have claimed that they cannot deal with complaints right now because they are too busy with COVID-19. My brother has submitted three medical complaints to his case manager, but she has not responded. On April 26, 2020, my brother submitted an application for compassionate release to the Warden. He has not received a response.

25. If transferred to home confinement, my brother can self-quarantine at my father's home at 1018 Elm Avenue, Modesto, California. There, he will have access to doctors who are familiar with his medical history and conditions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 15, 2020, at Hercules, California.



Jacque Wilson

EXHIBIT A

4-18-20

Hey Bro,

The captain came to our unit on 4-16-20 and said there are 33 confirmed cases of covid19 and 1 death. The news said there were 2 deaths here sofar. He also said as of 4-16-20 we can no longer use the phones or computers until further notice. We are confined in these units and people are sick and they wont even tell the guards instead they are in denial and all they are doing is spreading it to everyone that comes in contact with them. As far as what i have done since i have been incarcerated, i have completed the non residential drug treatment progams, the drug abuse program, Threshold re entry program, 2 parenting programs, Vocational training Electrical program, 3 college classes at Allan Hancock, I have completed 3 Alternative to Violece progams and have also taken one to become a facilitor for this program. I also facilitated an Alternative to Violece class. I became OSHA certified. I have completed KAIROS prison ministry class. I have also completed several other reentry classes. I have obtained my GED. I than went on to become a GED tutor. I took a training class to become a suicide cadre worker

and then went on to become a suicide cadre worker. I have taken and completed over 30 classes and have received over 25 certificates. I currently work at UNICOR here at Terminal Island. The UNICOR here is electronic recycling. I have worked my way up the latter to the #1 position here. I have not had an incident report since incorcareted. I have kept busy since the day i came to prison to turn my life around and help others along the way. I am not a threat to society. I have a re entry plan set in place. Ever since i have been incarcerated i have been diagnosed with hypertension. The medication i currently take is Lisinopril 20mg for hypertension HydroCHLOROthiazide 25mg for hypertension Atorvastatin for high cholesterol. The only way i can communicate with you is by mail until they let us use the phones and computers. If you mail me anything please send 2 copies because i am unable to copy anything right now. Thank you for all your help.

Love Your lil brother
Lance Wilson

P.S. before i got a job at UNICOR i worked on the construction crew.

EXHIBIT B

4-21-20

Hey bro.

Things are getting so bad here they are not even letting us get forms to write the staff up. People are getting taken out of here on the daily because they are sick with the COVID 19 virus. They are setting us up for a death sentence. It was on the news today KCAL 9 that terminal island is having a deadly outbreak and the 3rd highest infection rate in the nation in federal prisons. Please help it you can. I know there is so many more people that have it but they are not testing us they are just keeping us locked up inside, we get no fresh air, no communication with our loved ones besides writing letters. They say the warden will be coming to each of our units twice a week and she is no where to be seen. My friend had to go to the hospital today because he was having the symptoms. we all use the same common bathroom, showers, water faucet and tv room. write back to me it you can to make sure im still alive. Love Your Little Brother

Lance

P.S, the pappers that you sent with the 2241 motion that was ruled on for the immigration cases can you send me ~~the~~ a copy of the motion they filed the case no is 20-cv-02064-MMC
The document you sent was the response from the courts i would like to see the original one that they filed. Thank you

EXHIBIT C

4-23-20

Hey bro

How is everything going? So the warden finally shaved her face today. She just showed up to put some sign's on the walls about COVID-19. I asked her when are we going to be able to use the phones and computers so we can communicate with our loved ones and she said maybe by May 18 so until then i only will be able to communicate with you by mail. My pediatricians when i was young name was Dr Armand Hernandez. Remember he was the one that diaganosed me will Osgood Slaughtes disease lol. More and more cases of COVID 19 are popping up daily and it doesn't seem like it is getting any better. I sleep only 2 feet away from my celly. Well i hope you and the family is safe and out of harmsway.

Love Your lil brother

Lance

EXHIBIT D

4-28-20

Hey Bro,

So I got the compassionate release papers, I submitted it to the warden on monday 4/27/20. So now i just have to wait and see if she responds to me. They tested everyone here at Terminal Island for the COVID 19 virus. we are waiting for the results, They said it takes 3 days. So far we have 236 positive cases of COVID 19. Is there anyway i can file a motion to the courts to get an emergency hearing to try and get released. I am being detained under circumstances that violate my due process rights, specifically "substantive due process right" to be free from conditions of confinement that amount to punishment or create an unreasonable risk to my safety and health. Get back to me when you can. Thank you for all of your help. Tell Saeg & said thank you too.

Love Your lil bro

Lance

EXHIBIT E

4-29-20

Hey Bro

How is everything going. Just to give you another update, As of today there is 570 inmates that have tested positive and 10 staff. It is allover all of the news stations out here. They are doing nothing to seperate the sick from the healthy inmates. They are not responding to any of the cop outs to the case manggers. They are keeping us from the grievance process and will not give us any grievance forms. People are sick all around me. They are giving us a death sentence. The ~~likel~~ likelihood of becoming infected is enormous. The current conditions on this institution are inhumane. Im asking please for your help. Love Your little brother

Lance

EXHIBIT F

Hey Bro

How are you and the family. So i got my results back from the COVID 19 test and it came back positive. The symptoms i have been having is migrane headaches and body chills. The guy in charge of health services over here right now said that there is 642 positive cases so far and 10 staff positive and 5 deaths. On may 9th we should be able to use the phones. I wrote a letter that i wanted to send to Region and Grand prairie. Do you think this is a good idea. The case manager that is in this unit i am in said i should and she gave me the address. I will enclose the letter if you can read it and see if i should send it and if so can you send it for me and just put my name and address on the envelopes. I was also thinking about sending a copy of the letter to the courts. Tell me what you think. Things are out of control over here we have been on the news everynight If you can look at Golstein investigates on the news out here.

The address for Grand Prairie is

346 Marine Forces Dr.
Grand Prairie Tx, 75051

The address for Region is

Federal Bureau of Prisons
Western Regional office
7338 shoreline Dr.
Stockton CA 95219

Thank you for your help.

Love Your little Brother

4-29-20

Dear Sir or Maám:

I am an inmate at FCI-Terminal Island and i have been put through circumstances that violate my due process rights, specifically my "substantive due process right" to be free from "conditions of confinement that amount to punishment or create an unreasonable risk to my safety or health. For over a month inmates have been under stress, anxiety and hoplessness through the uncertainty of the current "global pandemic COVID19". It is well known to the inmate population the instructions of the Department of Justice those who are eligible or who are at a greater risk of getting infected with the COVID19 virus to be released to home confinment. While there is over 570 inmates infected with COVID19 virus and 10 staff infected here with two deaths. You would think that this institution would move to do just that but the facts are very worrysome For the first two weeks of April we were under this semi lockdown that is not reliable to allege a risk free enviorment. We have been kept

from a "grievence process", our cop-outs are not being answered and the casemanagers and counselors are no where to be found to address the home confinment opportunity. Presently i feel there is very little to no effort from the FCI staff to place inmates in home confinment and the inmates likelihood of becoming infected is enormous when introduced to confined spaces it can rapidly spread and indeed it has here at FCI Terminal Island. It is pertinent assessing in light of the present COVID 19 Pandemic that the current conditions in this institution amount to punishment and or create an unreasonable risk to my safety and health. I have an underlying health condition which is hypertension. Additionally i was born with asthma, although im am only on medication for my high blood pressure and high cholesterol, my asthma does bother me from time to time. I have provided the warden and their staff with my home confinement address. I am a

first time non violent offender. I was the only one in my case with the minimal perticipant role. I have employment upon my release. I pose no threat or danger to the community. Lastly i have completed over 30 classes while incarcarated which include, GED, non residential drug treatment, 3 college courses, and over 10 re entry classes. I went on to become a GED tutor, suicide cadre worker and i currently work for UNICOR. I have never been in any trouble or ever received a write up. Please look into my complaint and direct this institution to place me in home confinement. Thank you for your time and consideration

Lance Wilson
#72372-097
FCI Terminal Island
Po box 3007
San Pedro CA 90733.

EXHIBIT 2

DECLARATION OF JENNIFER VAN ATTA

I, Jennifer Van Atta, am over the age of 18 and fully competent to declare as follows:

1. My name is Jennifer Van Atta.

2. My husband is Maurice Smith. Maurice is 50 years old and is currently incarcerated at FCI Terminal Island in San Pedro, California. His BOP Register Number is 24299-298.

3. My husband has suffered from asthma since he was a child, is also pre-diabetic, and has hypertension.

4. On April 17, 2020, my husband was told that prisoners would not be able to use phones and computers until further notice. He has also been unable to make legal calls. My brother (husband) was allowed another five minute phone call on May 14, 2020. During this call, he consented to being a named plaintiff in this litigation. I make this declaration based on information conveyed to me by my husband over the phone before April 17 and through letters since then.

5. Before the outbreak began, my husband was housed in residential Unit B, an open-plan dorm with 60 prisoners. All 60 prisoners share 4 toilets, 4 sinks, and 3 showers. Two prisoners sleep in each bunk, and there is at most four feet of space between bunks.

6. Around April 14, 2020, my husband was moved to a makeshift living space in an old UNICOR warehouse. The warehouse was so unsanitary that it was simply not fit for human habitation. Mice, raccoons, wild cats, possums, and skunks all ran around the dirty concrete floor, and bats flew in through holes in the ceiling. Pigeons had nested inside, and were defecating on prisoners, who slept in fold-out lawn beds that were only three feet from the floor. The warehouse lacked potable water, hot water for showers, and any heating. My husband spent at least one night shivering uncontrollably and unable to sleep due to the cold. In addition, the

7. The Warden at Terminal Island has shown that she is indifferent to the suffering of my husband and other prisoners. My husband has personally addressed the Warden about his concerns, but was only told that the housing conditions met federal standards. My husband has also heard many of the staff complaining about the ineptness of prison leadership.

8. My husband was given one mask at the beginning of the outbreak, and has been reusing it ever since.

9. My husband has seen many of his fellow prisoners succumb to the virus. People who get sick often receive no treatment and are not removed from contact with my other inmates. Anyone with a temperature under 101 degrees is usually told to "hang in there" without treatment, no matter how sick they feel. My husband does his best to help sick people before they are finally taken away and given medical assistance.

10. Day after day, my husband hears news over the radio about more and more prisoners dying at Terminal Island. Having spoken to the Warden himself, he does not think that she or anyone else at the prison is willing or able to help him. He feels like a sitting duck, just waiting to be infected.

11. If transferred to home confinement, my husband would self-quarantine at my home, located at Carlsbad, CA. He would have access to medical personnel familiar with his medical conditions and history.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 14, 2020, at Carlsbad, CA.

Jennifer Van Atta

EXHIBIT 3

DECLARATION OF JACKELINE VAZQUEZ

I, Jackeline Vazquez, am over the age of 18 and fully competent to declare as follows:

1. My name is Jackeline Vazquez.

2. My brother is Edgar Vazquez. Edgar is 32 years old and is currently incarcerated at FCI Terminal Island in San Pedro, California. His BOP Register Number is 46907-007.

3. On April 16, 2020, my brother was told that prisoners would not be able to use phones and computers until further notice. He has also been unable to make legal calls. From then until May 10, 2020, the only way he has been able to communicate with myself and my father was through letters. On May 10, 2020, he was allowed one five-minute phone call. My brother was allowed another five minute phone call on May 14, 2020. During this call, he consented to being a named plaintiff in this litigation.

4. I make this declaration based on information conveyed to me by my brother through letters and over the phone.

5. Shortly after the outbreak at Terminal Island began, my brother was moved to a makeshift living space in an old UNICOR warehouse. The warehouse was infested with bats, pigeons, and cockroaches. It had no air conditioning, and 60 prisoners were packed into an open space and were made to share 3 showers and 3 toilets.

6. While at the warehouse, my brother began feeling sick. He became afraid that he had contracted COVID-19, and told prison staff that he needed immediate medical attention. Despite this, he was simply told to "hang in there" because his temperature was under 100 degrees.

7. Recently, my brother was moved to Unit J, an open-plan dormitory where he resides with 40 other prisoners. Prisoners in Unit J sleep only two feet apart from each other, making social distancing impossible. My brother understands

that all the people in Unit J have tested negative for COVID-19, and anyone who later tests positive is moved out.

7. Prisoners try to clean the dormitory every day, but the only cleaning supplies they have are watered down disinfectants, dirty mops, and dirty rags cut from their own blankets.

8. In addition, Terminal Island is also experiencing an outbreak of scabies – an infestation caused by tiny mites burrowing and laying eggs in the outer layer of human skin. According to my brother, Scabies has been circulating in Terminal Island for over a year, but the prison has not been able to keep the outbreak under control.

9. My brother understands that prisoners at Terminal Island have been experiencing significant delays in receiving any routine medical treatment not related to COVID-19.

10. If transferred to home confinement, my brother would self-quarantine at my house at [1516 Helen Belle Dr. Las Vegas, NV 89110]. He would have access to medical personnel familiar with his medical history.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 14, 2020, at [Las Vegas.]

Jackeline Vasquez

EXHIBIT 4

DECLARATION OF STEPHEN RINES

I, Stephen Rines, hereby declare:

1. I am a petitioner in the above-captioned action. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

2. I have asthma and was in wheelchair because of a spinal injury and have no feeling in my body below the waist. I was a prisoner at the federal prison at Terminal Island from about December 21, 2019, until my release on May 4, 2020. While I was there, I received totally inadequate medical care and observed practices that facilitated the transmission of COVID-19 and the staff and 1000+ prisoners at the prison.

3. Before going to Terminal Island, I was in the Metropolitan Detention Center awaiting sentencing on federal parole violation for failing to report to my parole officer. While I was in MDC, I had to be taken to the emergency room at White Memorial Medical Center because of problems I was having with my bladder. The doctor told me that my bladder had significant scarring and I had severe damage to my urethra. He set me up with a Foley Catheter to give my bladder and urethra a chance to heal. He also told me that in 30 days, I should see a urologist, have the Foley catheter removed and that I should use latex catheters thereafter.

4. I was sentenced to 8 months in prison and 18 months on supervised release and was taken to Terminal Island on or about December 21st. When I first arrived, I was put in a single cell in the special housing unit (SHU). I was supposed to have seen a urologist by late January and had my Foley Catheter removed, but that did not happen. Instead I developed an infection and had puss coming out of my penis. I moved from the SHU to the short stay hospital unit on about February 14, 2020, after I called my federal public defender to complain that I had not gotten my Foley removed and was developing an infection.

5. I did not get the Foley removed until after I was moved to the short stay hospital unit and I was never given the right catheters. Instead of latex ones, I was provided hard plastic ones that were too big, and using them has caused scarring in my urethra and sphincter. I regularly asked the medical staff for the correct catheters, and regularly responded "we have ordered them." But I never got them. Eventually, I was told that their delivery was delayed because of COVID-19. No doctor ever examined my infection. Instead medical staff just handed me an antibiotic with examining me or running any tests.

6. The short stay hospital unit had about nine rooms. Room 201 had three hospital beds separated by curtain, Room 202 had three beds, Room 203 had a single bed for someone with a handicap, Room 204 was a suicide watch room with a single bed. Room 205 had two or three beds. I was initially housed in Room 207, a suicide watch room with no handicap rails and no privacy. I was then moved to Room 203.

7. While I was in the short stay hospital unit I saw and heard about a variety of practices that clearly were not consistent with good public health and efforts to prevent the transmission of COVID-19. I am very familiar with hospitals and sound practices to prevent the risk of transmission contagious diseases from those who have them to those who are not yet infected because I have worked in ERs and ICUs as an electrician for many years. For example, I have had to work in the room of a woman who was sick and highly contagious and in so doing I learned the necessity of wearing personal protective equipment (PPE) into the room and then "de-gowning" the over-clothes you were provided, rather than keeping them on and bringing them into the next room I would be in to work on the electricity.

8. When I was in the short stay unit I observed that people coming back from the hospital be placed into the room with two other people who returned from the hospital on different days, thus defeating a lot of the purpose of quarantining. That practice did not end till April 25, 2020. I also often heard nurses complain that

they simply did not have enough beds for people who were suspected of or had tested positive for COVID-19. As a result, they would sometimes put someone who was symptomatic but had not yet gotten test results back in a room on the short stay unit and then move him back to general population so they could move in someone who was sicker, potentially exposing everyone in the housing unit to the risk of getting COVID-19.

9. Nurses also regularly complained about the shortage of PPE. I saw nurses going into rooms of people who were suspected of having COVID wearing gowns and then going into another room to see another patient without changing their gowns. Nurses did not get masks and face shields until mid-March and did not start changing gowns after leaving the room of someone suspected of having COVID-19 until mid-April. I also had officers come into my room to escort to the telephones on multiple occasions without wearing a mask. I did not get a mask until April 25.

10. I also heard nurses complain about delays in moving people from the short stay unit to the hospital. For example, I heard one nurse complain that she had checked the blood oxygen level of someone suspected of having the virus, it was low and his breathing was labored. She told me she had recommend that he immediately be transferred to the off-site hospital. But, instead he was kept at the short stay hospital unit for many hours before finally being taken to the hospital.

11. At no time while I was at Terminal Island ("TI") was I tested for COVID. I was released on May 4. Two officers who were not wearing masks came into my cell and escorted me to the release and delivery unit for processing for release. I was told I was going to be transported home by bus so I asked for a N95 mask, but was refused. All I had was a flimsy cloth mask. Eventually two officers took me in a wheelchair van to the Long Beach Greyhound Terminal but I had to return to TI because they did not have the bus ticket for me that they were supposed to have. Eventually they drove me to the crowded bus station at downtown LA,

where I caught a bus to Palmdale. During the whole trip I was worried I might infect someone on the bus with COVID or vice versa.

12. At no point since I was released did anyone from BOP contact me to see whether I had developed COVID symptoms or tested positive since leaving TI. They also did not provide me with any latex catheters for my trip and transition back to my community. They again provided the hard plastic catheters that scar my bladder and urethra.

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

Executed May 13, 2020, at Los Angeles, California.

EXHIBIT 5

DECLARATION OF SHAMSHER SAMRA, M.D.

I, Shamsher Samra, declare as follows:

1. I am an Assistant Professor of Clinical Medicine at University of California, Los Angeles and a faculty member in the Department of Emergency Medicine at Harbor-UCLA. I work clinically in the LA County jails and participate in jail reentry programs in Los Angeles County. I am a physician trained in forensic medical evaluations through Physicians for Human Rights. I am a founding member of both the Harbor-Hospital Based Violence Intervention Program and Trauma Recovery Centers. I completed by residency in Emergency Medicine at the University of California, Los Angeles. I received my M.D. from Harvard Medical School. Attached as Exhibit A is my curriculum vitae.

2. COVID-19 is a serious disease that has reached pandemic status, and is straining the health care systems around the world. As of May 14, 2020, at least 1.3 million people in the United States had received confirmed diagnoses of COVID-19. At least 83,000 people have died in the United States. Approximately 71,000 of the confirmed cases were in California, with more than 2,900 having died.[1] These numbers will continue to increase, perhaps exponentially. Moreover, these figures must be considered in light of nationwide shortages of COVID-19 tests, meaning the actual numbers are likely significantly higher than those reported.

3. The Federal Bureau of Prison's website confirms that Terminal Island has an inmate population above 1,000 but a rated capacity of only 779, indicating that it is overcrowded.[2] As of May 14, 2020, BOP's website reports that there are

[1] Coronavirus Disease 2019, Centers for Disease Control and Prevention, *available at* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

[2] Prison Rape Elimination Act Audit Report, Federal Bureau of Prisons, at page 6, *available at* https://www.bop.gov/locations/institutions/trm/prea_trm.pdf; Inmate Population Breakdown, Federal Bureau of Prisons, *available* at

a total of 712 people at Terminal Island who are currently or were recently positive for COVID-19, including 130 prisoners and 15 staff currently deemed positive, and 567 inmates reported as being "recovered" after previously testing positive.[3] The reported numbers change daily, and the BOP website does not show what criteria it is using to consider someone "recovered." On May 11, 2020, just four days ago, BOP was reporting that more than 690 prisoners were currently positive for COVID-19. At least 8 prisoners have died at Terminal Island due to coronavirus.[4]

4. COVID-19 is a novel respiratory virus. It is spread primarily through droplets generated when an infected person coughs or sneezes, or through droplets of saliva or discharge from the nose. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has prior immunity. The only way to control the virus is to use preventive strategies, including social distancing.

5. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as few as two days after exposure and their condition can seriously deteriorate in as few as five days (perhaps sooner) after that. It is believed that people can transmit the virus without being symptomatic and, indeed, that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic.

6. COVID-19 causes serious illness, with overall case fatality rates in the United States so far estimated at 5.8%. An estimated 20% of those who become infected and develop symptoms require significant medical intervention. While certain medical conditions increase the probability of death from infection,

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https://www.bop.gov/mobile/about/population_statistics.jsp

[3] COVID-19, Federal Bureau of Prisons, *available at* https://www.bop.gov/coronavirus/

[4] COVID-19, Federal Bureau of Prisons, *available at* https://www.bop.gov/coronavirus/

otherwise perfectly healthy people are also vulnerable to COVID-19 and may die as a result. For example, adults age 20 to 44 account for 20% of all hospitalizations and 12% of ICU admissions.[5]

7. Treatment for serious cases of COVID-19 requires significant advanced support. In particular, appropriate supportive care often requires ventilator assistance for respiration and prone positioning if a patient's condition worsens despite intubation and ventilation. Furthermore, hospitals across the country are deploying a variety of drug regimens, including antivirals and imunomodulators, in search of the most effective remedy against COVID-19. It is essential that patients have immediate access to such advanced supportive care, because the condition of patients who require hospitalization often deteriorates in rapid fashion. For instance, approximately 50% develop hypoxemia (shortage of oxygen in the blood or shortage of oxygen) by the eighth day. And as many as 29% develop Acute Respiratory Distress Syndrome (ARDS).[6] In addition to being a very lethal condition on its own, ARDS has a long and varied list of related complications that are as equally fatal: blood clots, collapsed lung, infections, and scarring of lung tissue.[7] In sum, for those individuals who experience more severe symptoms from COVID-19, immediate and substantial medical intervention is required.

8. The effects of COVID-19 are especially serious for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of

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[5] Coronavirus, COVID-19, Johns Hopkins Medicine, *available at* hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_#2

[6] Coronavirus, COVID-19, Johns Hopkins Medicine, available at hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_#2

[7] ARDS, Mayo Clinic, *available at* https://www.mayoclinic.org/diseases-conditions/ards/symptoms-causes/syc-20355576

any age with underlying health problems such as—but not limited to—weakened immune systems (which can be caused by a variety of conditions, including but not limited to cancer treatment, smoking, and immune weakening medications), moderate to severe asthma, diabetes, hypertension, serious heart and lung disease, severe obesity, liver disease, chronic kidney disease, and possibly pregnancy.[8] While the CDC typically classifies only people 65 and older as vulnerable, incarcerated individuals tend to be in poorer health than those in the general population, justifying the use of an earlier cutoff in classifying people deemed vulnerable to COVID-19.

9. Although individuals in the above-described populations are most vulnerable, even younger and healthier people can suffer severe consequences. For example, even healthier people who contract COVID-19 are susceptible to severe strokes and may require supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

10. The full extent of long-term sequela on cardio and cerebrovascular diseases and other organ damage is unknown at this time in light of the novel nature of COVID-19. However, preliminary evidence suggests COVID-19 may render lasting organ damage in even minimally symptomatic or completely asymptomatic patients. For example, COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, can cause a permanent loss of respiratory capacity. Furthermore, COVID-19 may target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's

[8] Coronavirus Disease 2019, Centers for Disease Control and Prevention, *available at* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.

11. In light of the above, an outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure. In the absence of a vaccine and a cure, a significant number of people who are infected with the virus will die. Buttressing these concerns, it is not yet clear whether people who have already been infected with COVID-19 gain immunity against future infection. To the extent that the health care infrastructure is overloaded, people will die unnecessarily because necessary respirators and hospital facilities are unavailable.

12. Public health authorities recommend a number of preventative steps to help prevent or decrease the spread of COVID-19, with perhaps the most important measure being social distancing. However, as the CDC and BOP both appear to acknowledge, correctional facilities are inherently limited in their abilities to implement such measures. For example, the BOP's modified operating directive is inadequate, in part, because it only requires social distancing "as much as practicable."[9] Indeed, social distancing in ways that are recommended by public health officials can be difficult, if not impossible, in prisons, placing people at risk, especially when a facility is at or above population capacity. Therefore, even if the conditions at Terminal Island were ideal (which they are not) it would require a monumental effort to ensure the safety of prisoners and staff.

13. I understand the following to be allegations in the Complaint. If these allegations are confirmed true, the conditions at Terminal Island are deeply concerning:

- Terminal Island has a rated capacity of 779, but currently houses

[9] Modified Operating Directive, Federal Bureau of Prisons, *available at* https://www.bop.gov/coronavirus/covid19_status.jsp

over 1,000 prisoners.

- Terminal Island has nine residential units, five of which are large communal open dormitories that house approximately 100-150 prisoners. Each of these dormitories contain long rows of double bunk beds which are only 2-3 feet apart and not separated by walls. Prisoners share communal bathrooms.
- Of the remainder, two residential units are double-occupancy cells, where two prisoners share a room with beds only 2-3 feet apart. Prisoners in the double-occupancy cells also share communal bathrooms.
- Terminal Island staff have attempted to reduce overcrowding in the residential units by moving prisoners into tents and alternative housing units set up in warehouses. At least some of these temporary units are unsanitary, with reports of broken windows and ceiling leaks; infestations of rodents, bats, and pigeons; no heat or running water; floors littered with feces; and up to 60 prisoners sharing four sinks, four toilets, and four showers.
- Only about half of staff are wearing masks. Masks were not distributed to prisoners until late April. Prisoners are forced to reuse a single cloth mask for at least one week. No other personal protective equipment has been distributed. Only about half of staff are wearing masks or other personal protective equipment. Hand sanitizer also was not made available to prisoners until late April.
- For weeks after its first positive cases, Terminal Island maintained a policy of testing only symptomatic prisoners, even though COVID-19 can be transmitted by asymptomatic or

pre-symptomatic individuals. This policy did not change even after April 15, 2020, when Terminal Island reported its first COVID-19 related death. Terminal Island only begin to test its entire prisoner population on or around April 28, when over half had already been confirmed as infected. Aside from that one-time test of the entire population, Terminal Island is not conducting any further testing, including prisoners who may have been exposed to infected persons or "recovered" COVID-19 patients before they return to the general population.

- Terminal Island's efforts to isolate infected persons originally consisted of taking those who tested positive out of their residential units and isolating them in separate buildings. In carrying out this attempt at isolation, Terminal Island has frequently transferred prisoners, with one side effect being that prisoners have been exposed to three or more cellmates or bunkmates just within the weeks since the outbreak begin. There is now only one unit that has been designated as "clean," or reserved for persons who have tested negative for COVID-19.
- Terminal Island's outbreak started with a single staff member. By April 16, 2020, Terminal Island had 33 confirmed cases. Within two weeks, that number had climbed by more than 1700%, with Terminal Island reporting 570 confirmed cases. As of May 10, 2020, approximately 60% of the prisoners had received positive diagnoses for COVID-19, with eight having died from complications relating to the illness. BOP currently reports that 130 prisoners at Terminal Island are positive and 567 prisoners are "recovered."
- Terminal Island is a Care Level 3 medical facility, designed to

> "provid[e] specialized or long-term medical or mental health care in a correctional environment."[10] According to BOP guidelines on Care Level classification, "Care Level 3 inmates are outpatients who have complex, and usually chronic, medical or mental health conditions and who require frequent clinical contacts to maintain control or stability of their condition."[11]

14. These conditions make it virtually impossible to ensure the safety of prisoners who remain housed at the facility if the current course is maintained. Even if the government made best efforts, effective social distancing is out of the question. Indeed, this combination of factors practically ensures that all remaining prisoners will eventually contract COVID-19 unless extraordinary measures are taken now. As if more evidence were needed of Terminal Island's inability to ensure the safety of its prisoners, more than 60% of them have recently tested positive for COVID-19. These failures are all the more alarming in light of Terminal Island's classification as a Level 3 Care facility designated specifically for prisoners who have chronic underlying conditions.

15. Moreover, it is my understanding that BOP now contends that a substantial number of the prisoners who recently tested positive have "recovered." To the extent these prisoners have actually recovered from the illness, that does not absolve the need for preventive measures. In particular, it is not yet clear whether people who have been infected develop immunity against future infection by COVID-19.

16. Furthermore, I do not know how BOP has decided which prisoners to

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[10] Prison Rape Elimination Act Audit Report, Department of Justice, at page 2, *available at* https://www.bop.gov/locations/institutions/trm/TRM_prea.pdf

[11] Care Level Classification for Medical and Mental Health Conditions or Disabilities, Federal Bureau of Prisons, at page 3, *available at* https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf

classify as "recovered." The need for continued rigorous preventive measures is only heightened if BOP has not relied on appropriate methods for determining whether prisoners have in fact recovered. In an ideal scenario, an individual would only be deemed "recovered" after testing negative. Relying instead, for instance, on patient reports of symptoms may not be sufficient in a correctional setting, where prisoners may be reluctant to share information with staff. Furthermore, asymptomatic individuals can still be carriers of the disease. And in a large communal living space, where social distancing cannot be strictly adhered to, individuals should be tested regularly in order to quickly identify and isolate anyone who may contract COVID-19 before it spreads through the population.

17. I have also reviewed the declaration submitted by Jacques Wilson, the brother of a prisoner, Lance Wilson ("Wilson") housed in Unit F. In addition to some of the representations above, the declarant indicates that: (1) prisoners stand in line "for some time" in the lobby to receive meals and medications and that during this they are unable to practice social distancing; (2) Wilson has had asthma most his life and has been diagnosed with hypertension while incarcerated, for which he is prescribed the medications Lisinopril and Hydrochlorothiazide; (3) Wilson was informed on May 1 that he tested positive for COVID-19 and experienced migraines, body chills, and frequent sweating in his sleep, but has not had any treatment, monitoring, or access to a physician to discuss his prognosis or treatment options; and (4) Wilson has been left in his regular housing unit, where none of the other prisoners who have tested positive for COVID-19 are receiving treatment or consultations with physicians.

18. Assuming these allegations are accurate, the health care delivery system at Terminal Island is failing to provide the minimal level of acceptable care. In addition to the noted failures to institute an effective regimen of social distancing, Wilson's declaration highlights the failure to monitor prisoners and to treat those who have become infected—and even worse, have displayed notable symptoms.

Wilson paints a grim picture indeed, of outright failure to provide access to physicians or any modicum of treatment. Particularly in light of Terminal Island's status as a Level 3 Care facility, this is wholly inadequate.

19. Furthermore, based on the conditions depicted in the allegations from the Complaint and Wilson's declaration, it is questionable whether the healthcare system at Terminal Island is even capable of responding to the dire situation it now faces. Indeed, vulnerable individuals—who comprise a larger portion of Terminal Island's population than in the average prison—are at particularly high risk for materially negative health consequences that will require aggressive and immediate medical intervention. As a result, the treatment load at Terminal Island will be greater than normal, because more prisoners will require severe medical intervention. In the context of a very limited healthcare system at a prison facility (and possible staffing shortages due to COVID-19 outbreak among staff), the inability to swiftly identify those prisoners in need of substantial and proactive medical intervention and either begin an appropriate treatment regimen or transport them to a civilian hospital will only cause needless pain and deaths. And this additional strain on the healthcare system does not even account for the already substantial strain that exists at a facility like Terminal Island, where many prisoners require regular medical treatment for chronic underlying conditions.

20. In light of the above, in my opinion BOP should take immediate steps to dramatically downsize the population at Terminal Island, with priority given to those at high risk of harm due to their age and health status and thus are likely to require a disproportionate amount of medical resources. This will both allow Terminal Island to implement more effective preventive and treatment measures while simultaneously granting released or transferred prisoners access to minimally acceptable living conditions.

21. Perhaps most importantly, downsizing will allow for more effective social distancing measures at Terminal Island while simultaneously reducing the

strain placed on prison staff by the need to monitor and treat prisoners. Although BOP has attempted to redress the overcrowding by way of temporary shelters, I am informed that these makeshift dormitories are rife with sanitation problems that, coupled with the communal living arrangement, means they are unlikely to meaningfully slow or prevent the spread of COVID-19. In light of the already high infection rates at Terminal Island, any reduction in prisoner population will also allow prison staff to more closely monitor the conditions of infected prisoners for signs that immediate medical intervention is required. Relatedly, the reduction in population while implementing downsizing measures helps prevent overloading prison staff such that they can continue to ensure the safety of incarcerated people.

22. Furthermore, immediate downsizing that prioritizes prisoners who are elderly and those with underlying health conditions reduces the likelihood they will contract the disease (either for a first or subsequent time) or suffer severe medical consequences as a result of being infected. Reducing the spread and severity of infection in a prison slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the strain on local community resources and infrastructure.

23. Downsizing from a facility with infection rates as high as Terminal Island may be done safely, minimizing the risk of increasing infection rates in the community. In particular, it is imperative that prisoners be tested prior to release. But even prisoners who receive confirmed diagnoses of COVID-19 may be safely released to the community. If they are asymptomatic, they must be required to self-quarantine and follow other recommendations of public health officials. If they are experiencing symptoms, they will likely receive superior healthcare if released from custody due to the present conditions at Terminal Island.

24. The above measures, especially if implemented immediately, can slow or stop the spread of infection (or re-infection) and ensure appropriate and proactive treatment of infected prisoners, to the benefit of prisoners and staff and, ultimately,

the community at large.

25. In addition to downsizing, and to the extent they are not already being implemented, the following steps should immediately be mandated of the Respondents in order to protect any prisoners who remain in custody:

a. Social Distancing. The prison must ensure that prisoners are able to maintain adequate social distancing during required or necessary activities, such as collecting food, eating, and receiving medications.

b. Immediate and Continued Testing. Patients (both staff and prisoners) who require testing, based on public health recommendations and the opinion of a qualified medical professional, should be tested for COVID-19, including to the extent public health recommendations call for continued (or repeat) testing of individuals who have previously been tested.

c. Immediate Screening. Defendants must be required to screen each employee or other person entering the facility every day to detect fever over 100 degrees, cough, shortness of breath, and/or exposure to someone who is symptomatic or under surveillance for COVID-19 or screening as required by public health authorities. A record should be made of each screening.

d. Quarantine. The prison must establish non-punitive quarantine for all individuals believed to have been exposed to COVID-19, but not yet symptomatic, and non-punitive isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely inflicted with COVID-19 must utilize protective equipment as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the incarcerated population and each other.

e. Institutional Hygiene. The prison must be required to provide adequate disinfection of all high-touch areas and cells.

f. Personal Hygiene. The prison must be required to provide hand

soap, disposable paper towels, and access to water to allow prisoners to wash their hands on a regular basis, free of charge and ensure replacement products are available as needed. Further, hand sanitizer with alcohol must be declassified temporarily as contraband. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and prisoners should be allowed to use hand sanitizer with alcohol when they are in locations or activities where hand washing is not available. Prisoners should also be permitted daily access to showers and clean laundry. Correctional officers should be required to wear personal protective equipment, consistent with the CDC guidance, including masks and gloves, when interacting with any person or when touching surfaces in cells or common areas. Finally, correctional officers should also wash their hands, use hand sanitizer, or change their gloves both before and after interacting with any person or touching surfaces in cells or common areas.

g. Waive Copays. There must be a waiving of copays for medical evaluation and care related in any way to COVID-19 and/or its symptoms. A waiver of these types of copays is necessary to avoid disincentivizing patients from requesting medical treatment. Patients with symptoms of possible COVID-19 should be seen quickly.

h. Personal Protective Equipment. Those prisoners with a cough should be provided masks as soon as they inform staff of this symptom or staff notice this symptom. Staff should also be required to wear facemasks, gowns or other body coverings, eye protection, and gloves.

i. Supply Chain. The prison must be required to identify the supplies and other materials upon which the institution is dependent, such as food, medical supplies, certain medicines, cleaning products, etc., and prepare for shortages, delays or disruptions in the supply chain.

26. In sum, reducing the number of individuals imprisoned at Terminal Island immediately is necessary for the health and safety of the prisons and our

communities. This population reduction should begin with the most medically vulnerable which includes those over age 50 and those with CDC-defined underlying health conditions.

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

Executed May 15, 2020, at Los Angeles, California

SHAMSHER SAMRA, M.D.

EXHIBIT A

Shamsher Samra, MD, MPhil

CURRICULUM VITAE

PERSONAL HISTORY:

Business address:	Harbor-UCLA Medical Center Division of 1000 West Carson Street Torrance, California 90509
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Date of Birth:	May 5, 1986
Place of Birth:	Los Angeles, California
Citizenship:	U.S. Citizen

EDUCATION and TRAINING:

Stanford University, Stanford, California
B.S., Biological Sciences 8/04-06/07

Cambridge University, Cambridge, UK
MPhil, Development Studies
Gates Cambridge Fellowship 08/07-06/08

Harvard Medical School, Boston, Massachusetts
MD 08/08-06/13

Harvard Kennedy School of Government
Urban Policy and Human Rights 08/14-12/14

UCLA Medical Center-Olive View Medical Center
Residency: Emergency Medicine 07/13-06/17

Chief Resident UCLA Medical Center-Olive View Medical Center
Residency: Emergency Medicine 07/16-06/17

LICENSURE:

State of California, A134884 02/15 -

Drug Enforcement Agency 02/15 -

CERTIFICATION:

Diplomate, American Board of Emergency Medicine 06/14/18

PROFESSIONAL EXPERIENCE:

Assistant Professor Emergency Medicine 08/17 -
Harbor-UCLA Medical Center
Los Angeles, California

Attending Physician Correctional Health Services 08/17-
Twin Towers Correctional Facility
Los Angeles, California

Medical Director Whole Person Care Reentry 08/18 –
Department of Health Services
Los Angeles, California

Course Director Introduction to Social Medicine 09/18 –
UCLA David Geffen School of Medicine
Los Angeles, California

Co-Director Trauma Recovery Center 12/17-
Harbor-UCLA Medical Center
Torrance, California

Co-Director Hospital Based Violence Intervention Program 3/19 -
Harbor-UCLA Medical Center
Torrance, California

PROFESSIONAL ACTIVITIES:

Committee Services

1. UCLA International and Domestic Health Equity 01/17 -
2. Correctional Health Services Care Transitions 08/17 -
3. Whole Person Care Delivery Systems Integration 01/18 – 06/19
4. Whole Person Care Clinical Innovations 01/18 – 06/19
5. Hospital Based Violence Intervention Consortium 12/18 –
6. DPH Trauma Prevention Initiative 06/18 –
7. Harbor UCLA Diversity Committee 06/18 -
8. Harbor Supports Undocumented Patients 06/18 -
9. Los Angeles Office of Violence Prevention 06/19 -
10. Co- Lead Los Angeles Hospital Based Violence Intervention Consortium 06/19 -

Community Service

1. Strategic Action for a Just Economy Board Member 12/13- 12/18
2. Doctors for Global Health Board Member 08/17 –
3. Tijuana Border Wound Clinic 06/16 –
4. Frontline Wellness Network Founding Member 08/17 –
5. Southern California Physicians for Health Equity 06/18 -

Professional & Scholarly Associations

1. Society for Academic Emergency Medicine 10/14 -
2. American College of Emergency Physicians 10/14 –
3. ACEP Social Emergency Medicine Section 06/17 –
4. SAEM Social Emergency Medicine Interest Group 01/18 -

HONORS AND SPECIAL AWARDS:

1. Gates- Cambridge Fellowship 06/07 – 06/08

RESEARCH GRANTS AND FELLOWSHIPS RECEIVED:

Public Health Institute 02/2019-06/2020
California Bridge Program Grant
Goal: Implement and study opiate treatment
Role: Co- PI

California Community Foundation 04/2018-04/2020
Hospital Based Violence Intervention Grant
Goal: Implement a hospital-based violence intervention program
Role: Co-PI

California Victims Compensation Board 04/2019-04/2021
Trauma Recovery Center Grant
Goal: Establish a Trauma Recovery Center
Role: Co-PI

Whole Person Care Los Angeles 06/2019-06/2021
Hospital Based Violence Intervention Grant
Goal: Expand Hospital Based Violence Intervention Programming Regionally
Role: PI

LECTURES AND PRESENTATIONS:

<u>Local Lectures:</u>

1. “Neurogenic Shock” 08/2015
   Emergency Medicine Residents’ Conference, UCLA-Olive View Medical Centers, Los Angeles. California,
2. “Mechanical v. Traditional Chest Compressions” 05/2015
   Emergency Medicine Residents’ Conference, UCLA-Olive View Medical Centers, Los Angeles. California
3. ED Based Interventions for At-Risk Drinking” 05/2016

Emergency Medicine Residents' Conference, UCLA-Olive View Medical Centers, Los Angeles. California, May 2016

4. Introduction to Trauma 06/2016
   Emergency Medicine Residents' Conference, UCLA-Olive View Medical Centers, Los Angeles. California
5. Course Director "Introduction to Social Medicine" 08/2017
   David Geffen School of Medicine, Los Angeles California
6. Thoracic Trauma 09/2016
   Emergency Medicine Residents' Conference, UCLA-Olive View Medical Centers, Los Angeles. California
7. Care for the Homeless Patient 10/2016
   Emergency Medicine Residents' Conference, UCLA-Olive View Medical Centers, Los Angeles. California
8. Correctional Health and Primary Care Connections 01/2019
   Department of Health Services Reentry Learning Collaborative, California Endowment. Los Angeles, California
9. Health Equity and Liberation Medicine 02/2019
   Harbor-UCLA Medical Center Grand Rounds, Carson California
10. Structural Vulnerability 08/2019
    Harbor-UCLA Emergency Medicine Grand Rounds , Carson CA
11. Social Emergency Medicine CPC 10/2019
    Harbor-UCLA Emergency Medicine Grand Rounds , Carson CA
12. Hospital Based Violence Intervention 10/2019
    LAC-USC Emergency Medicine Grand Rounds, Los Angeles California
13. Community Mental Health 11/2019
    Charles Drew Medical School Health Equity Course, Los Angeles California
14. Less Than Lethal Weapons 01/2020
    Harbor-UCLA Emergency Medicine Grand Rounds, Carson CA

Regional Lectures:

1. Barriers to the "Right To Health" Amongst Patients of a Public Emergency Department Following Implementation of the Affordable Care Act 03/2015
   Western Regional SAEM Conference, Tucson, AZ
2. Structural Vulnerability 05/2017
   Emergency Medicine All-LA Regional Conference, LAC-USC Medical Center, Los Angeles, California
3. Craniofacial Complications 07/2017
   Emergency Medicine Conference, Kaweah-Delta Hospital, Visalia, California
4. Development and Implementation of a Novel Medicaid Enrolment Process for Correctional Health Settings. 06/2018
   Southern California DII Conference. Los Angeles, California
5. Incarceration and Health 05/2019
   All-LA Regional Conference, Harbor-UCLA, Los Angeles, California
6. Injuries from "Non-Lethal" Weapons 08/2019
   Harbor UCLA Regional Trauma and Critical Care Conference, Carson, CA.

National Lectures:

1. Barriers to the “Right To Health” Amongst Patients of a Public Emergency Department Following Implementation of the Affordable Care Act. 05/2015
   National Society of Academic Emergency Medicine Conference. San Diego
2. A Case of Migrating Chest Pain 04/2016
   Council of Emergency Medicine Residency Directors National Conference, Annual Lecture, Nashville, TN
3. Craniofacial Complications 05/2017
   Society of Academic Emergency Medicine Conference, Orlando FL
4. Undocumented Emergency Department Patients: We Can Do Better 05/2018
   National Society of Academic Emergency Medicine Conference. Indianapolis
5. Migrant Heath and Liberation Medicine 12/2018
   Second Annual Health of Migrants Conference. Galveston, Texas.
6. Health Equity and Emergency Medicine: A Perfect Fit 05/2019
   Society of Academic Emergency Medicine Conference, Las Vegas NV
7. Leveraging Community Health Workers to Improve Population Health 06/2019
   Americas Essential Hospitals Vitals Conference, Miami FL
8. Breaking the Cycle: Hospital Based Violence Intervention 06/2019
   Americas Essential Hospitals Vitals Conference, Miami FL

International Lectures:

1. Discapacidad: Trauma de Sistema Nervioso Central: Lesiones del Cerebro y Medula Espinal 02/2017
   Pre-hospital Training Program. Managua, Nicaragua.

PUBLICATIONS/BIBLIOGRAPHY:

RESEARCH PAPERS

A. Research Papers - Peer Reviewed

1. Hale MB, Krutzik PO, **Samra SS**, Crane JM, Nolan GP, 2009 Stage Dependent Aberrant Regulation of Cytokine-STAT Signaling in Murine Systemic Lupus Erythematosus. PLoS ONE 4(8): e6756. doi:10.1371/journal.pone.000675
2. **Samra SS**, Crowley J, Fawsi M, 2011 The right to water in rural Punjab: Assessing equitable access to water in the context of the ongoing Punjab Rural Water Supply Project. Health and Human Rights Journal. Volume 13, No. 2.
3. **Samra, SS** et al. "Barriers to the Right to Health Among Patients of a Public Emergency Department After Implementation of the Affordable Care Act." Health equity vol. 3,1 186-192. 2 May. 2019, doi:10.1089/heq.2018.0071
4. **Samra, SS**, Taira, B., Pinheiro, E., Trotzky-Sirr, R., & Schneberk, T. (2019). Undocumented Patients in the Emergency Department: Challenges and Opportunities. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*.

B. Research Papers - Peer Reviewed (In Press)

5. Saadi A, Cheffers ML, Taira B, Trotzky-Sirr R, Parmar P, **Samra SS**, Morrison JL, Shah S, Schneberk TW, "Building Immigration-Informed, Cross-Sector Coalitions: Findings from the Los Angeles County Health Equity for Immigrants Summit," Health Equity

EDITORIALS

1. Maciag K, **Samra SS**, Sorscher SS. 03/2009
   Harvard as Big Pharma. The Harvard Crimson.

ABSTRACTS

1. **Samra SS,** Taira B, Richman, M, McCullough. "Barriers to the "Right To Health" Amongst Patients of a Public Emergency Department Following Implementation of the Affordable Care Act." Western Regional Society of Academic Emergency Medicine Conference, Tucson, AZ, March 2015
2. **Samra SS,** Taira B, Richman, M, McCullough. "Barriers to the "Right To Health" Amongst Patients of a Public Emergency Department Following Implementation of the Affordable Care Act." National Society of Academic Emergency Medicine Conference. San Diego, May 2015
3. **Samra SS,** Taira B, Hseih D, Schneberk, T. "Undocumented Emergency Department Patients: We Can Do Better" National Society of Academic Emergency Medicine Conference. Indianapolis, Indiana , May 2018
4. Taira, B, Torres, J, Nguyen, A, **Samra SS. "**Emergency Department Provider Knowledge of and Preferences for Language Assistance for the Care of Limited English Proficiency Patient" National Society of Academic Emergency Medicine Conference. Indianapolis, Indiana , May 2018
5. Schneberk T, **Samra SS**. "Creation of a novel medico-legal conduit to assist undocumented individuals presenting to the Emergency Department to address immigration legal needs" National Society of Academic Emergency Medicine Conference. Indianapolis, Indiana , May 2018

6. Hsieh D, **Samra SS**, “Development and Implementation of a Novel Medicaid Enrolment Process for Correctional Health Settings.” Southern California Dissemination, Implementation, and Improvement Conference. Los Angeles, California. June 2018
7. Terao N, Hsieh D, **Samra SS**, Salas A, Murray J, Deane M, Carrillo P. “Implementing an Effective Hospital-Based Violence Intervention Program at a Los Angeles County Trauma Center” Southern California Dissemination, Implementation, and Improvement Conference. Los Angeles, California. June 2018
8. Kiwon Yoo, MPH, **Shamsher Samra, MD**, MPhil, Karen Bernstein, MPH and Dennis Hsieh, MD, JD, Reducing Morbidity, Mortality, and Recidivism for Jail and Prison Re-Entry Patients: The Los Angeles County Whole Person Care Re-Entry Program. American Public Health Association Conference 2019
9. Susie Lee, Dennis Hsieh, MD, JD, **Shamsher Samra, MD, MPhil**, Clemens Hong, MD, MPH, Henna Zaidi, MPP, MPH and Sasha Rumburg. Longitudinal Patient Accompaniment Services by Community Health Workers (CHWs): Improving Coordination of Primary Care Services (PCS) for High-Risk Populations in Los Angeles County. American Public Health Association Conference 2019
10. Natalie Terao, MD, MS, Dennis Hsieh, MD, JD, **Shamsher Samra, MD, MPhil**, Brittney Mull, MD, MPH, Joseph Friedman, MPH, Tony Kuo, MD, MSHS, Noel Barragan, MPH, Molly Deanne, MD, Antoinette Salas, RN, BSN, MICN, Arcelia Tavarez, Paul Carrillo and Jennifer Murray, MSW, LCSW. Implementation and Evaluation of a Hospital-Based Violence Intervention Program at a Los Angeles County Trauma Center. American Public Health Association Conference 2019
11. **Shamsher Samra, MD, MPhil**, Dennis Hsieh, MD, JD, Karen Bernstein, MPH and Kiley Hoffman, MSW. Expansion of a Jail Based Primary Care Reentry Program. American Public Health Association Conference 2019
12. Tony Kuo, MD, MSHS, Noel Barragan, MPH, **Shamsher Samra, MD, MPhil** and Rochelle Dicker, MD. Population Health Perspective on Violence Prevention in the Hospital Setting: Intervening During a “Teachable Moment” in a Victim’s Life. American Public Health Association Conference 2019
13. Joseph Friedman, MPH, **Shamsher Samra, MD, MPhil**, Dennis Hsieh, MD, JD, Vincent Chong, MD, MS, Lee Plantmason, MD, Todd Schneberk, MD, MSHPM, MA, Karen Kwaning, Molly Deanne, MD, Brittney Mull, MD, Philippe Bourgois, PhD and Rochelle Dicker, MD. Racial and Geographic Disparities in Violent Injury Rates: A Baseline Assessment for a Los Angeles Hospital-Based Violence Intervention Program. American Public Health Association Conference 2019
14. Dennis Hsieh, MD, JD, **Shamsher Samra, MD, MPhil,** Kiwon Yoo, MPH, Karen Bernstein, MPH and Mark Burstyn, Pharm.D. Providing a 30 Day Supply of Medications upon Discharge from Los Angeles County Jails. American Public Health Association Conference 2019

EXHIBIT 6

DECLARATION OF MARC STERN, M.D.

I, Marc Stern, declare as follows:

1. I am a physician, board-certified in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I am a court-appointed medical expert in the class action *Parsons v. Ryan*, CV-12-00601-PHX-ROS. Currently, I am the Medical Advisor for the National Sheriffs' Association on matters related to preventive measures responding to COVID-19. Additionally, in 2009, at the request of the California Receiver Clark Kelso, I toured 10 California state prisons to assess whether or not the Receiver's assignment—to restore the delivery of health services within the California state prisons to constitutionally adequate levels—had been completed. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease that has reached pandemic status, and is straining the health care systems around the world. As of May 15, 2020, at least 1.3 million people in the United States had received confirmed diagnoses of COVID-19. At least 83,000 people have died in the United States. Approximately 71,000 of the confirmed cases were in California, with more than 2,900 having died. These numbers will continue to increase, perhaps exponentially. Moreover, these figures must be considered in light of nationwide shortages of COVID-19 tests, meaning the actual numbers are likely significantly higher than those reported.

3. Terminal Island has a population above 1,000 but a rated capacity of only 779, indicating that it is overcrowded. As of May 15, 2020, the Federal Bureau of Prison's ("BOP") website reports that there is a total of 712 people at Terminal

Island who are currently or were recently positive for COVID-19, including 130 residents and 15 staff currently deemed positive, eight resident deaths, and 567 residents reported as being "recovered" after previously testing positive. The BOP website does not show what criteria it is using to consider someone "recovered."

4. COVID-19 is a novel respiratory virus. It is spread primarily through droplets generated when an infected person coughs or sneezes, or through droplets of saliva or discharge from the nose. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has prior immunity. The only way to control the virus is to use preventive strategies, including social distancing.

5. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as few as two days after exposure and their condition can seriously deteriorate in as few as five days (perhaps sooner) after that. It is believed that people can transmit the virus without being symptomatic and, indeed, that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic.

6. Treatment for serious cases of COVID-19 requires immediate and substantial medical intervention.

7. The effects of COVID-19 are especially serious for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as—but not limited to—weakened immune systems (which can be caused by a variety of conditions, including but not limited to cancer treatment, smoking, and immune weakening medications), moderate to severe asthma, diabetes, serious heart and lung disease, severe obesity, liver disease, and possibly pregnancy. While the CDC typically classifies only people 65 and older as vulnerable, incarcerated individuals tend to be in poorer health than those in the general population, justifying the use of an earlier cutoff in classifying people deemed vulnerable to COVID-19.

8. In light of the above, an outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure. In the absence of a vaccine and a cure, a significant number of people who are infected with the virus will die. Buttressing these concerns, it is not yet clear whether people who have already been infected with COVID-19 gain immunity against future infection. To the extent that the health care infrastructure is overloaded, people will die unnecessarily because necessary respirators and hospital facilities are unavailable.

9. Public health authorities recommend a number of preventive steps to help prevent or decrease the spread of COVID-19, with perhaps the most important measure being social distancing.

10. Prisons are congregate environments, *i.e.*, places where people live and sleep in close proximity. Many people live in dormitory-style units with multiple rows of bunk beds close together or in small multi-person cells that often surround common areas where incarcerated people crowd together during the day. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible, in prisons, even when the population is under design capacity. When prisons are at or above capacity, it becomes even more difficult to implement appropriate social distancing measures.

11. Infectious diseases that are transmitted via the air or touch (like COVID-19) are more likely to spread, placing people at risk. For these reasons, if—but more likely when—COVID-19 is introduced into a prison, the risks of spread is greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in two other congregate environments: nursing homes and cruise ships.

12. But prisons actually have an attribute that makes them more dangerous than cruise ships. Unlike cruise ships, prisons are not closed systems. Staff, new detainees, attorneys, and inanimate objects—all potential vectors for virus—are introduced into the system every day. Thus, even if the government makes best efforts to follow preventive guidelines, the introduction of virus into a detention

center is almost inevitable. Moreover, because staff and some visitors travel each day from the facilities back to their homes, when infection develops in the facility, there is also significant risk that the infection will be transmitted *outside the facility*, to the family and friends of staff and visitors. In short, the risks that confront individuals at detention facilities such as Terminal Island stem from their very nature as congregate environments. Even if the healthcare provided were excellent, there would still be substantial risk; if the healthcare provided were substandard, those substantial risks are only elevated.

13. I understand the following to be allegations in the Complaint. If these allegations are confirmed true, the conditions at Terminal Island are deeply concerning:

- Terminal Island has a rated capacity of 779, but currently houses over 1,000 residents.
- Terminal Island has nine residential units, five of which are large open dormitories that house approximately 100-150 residents. Each of these dormitories contain long rows of double bunk beds which are only two to three feet apart and not separated by walls. Residents share communal bathrooms.
- Of the remainder, two residential units are double-occupancy cells, where two residents share a room with beds only two to three feet apart. Residents in the double-occupancy cells also share communal bathrooms.
- Terminal Island staff have attempted to reduce overcrowding in the residential units by moving residents into tents and alternative housing units set up in warehouses. At least some of these temporary units are unsanitary, with reports of broken windows and ceiling leaks; infestations of rodents, bats, and pigeons; no heat or running water; floors littered with feces; and

up to 60 residents sharing four sinks, four toilets, and four showers.

- Only about half of staff are wearing masks.
- Terminal Island is not conducting any testing of residents who are "recovered" before they return to the general population.
- Terminal Island's outbreak started with a single staff member. By April 16, 2020, Terminal Island had 33 confirmed cases. Within two weeks, that number had climbed by more than 1700%, with Terminal Island reporting 570 confirmed cases. As of May 10, 2020, approximately 60% of the residents had received positive diagnoses for COVID-19, with seven having died from complications relating to the illness. BOP currently reports that 130 residents at Terminal Island are positive and 567 are "recovered."
- Terminal Island is a Care Level 3 medical facility, designed to "provid[e] specialized or long-term medical or mental health care in a correctional environment." According to BOP guidelines on Care Level classification, "Care Level 3 inmates are outpatients who have complex, and usually chronic, medical or mental health conditions and who require frequent clinical contacts to maintain control or stability of their condition."

14. These conditions, if true—a track record of not being able to prevent predictable and widespread infection, continued widespread infection, unsanitary living conditions, unavailability of running water in living areas, inadequate testing, and most importantly overcrowding—make it exceedingly difficult, if not impossible, to ensure the safety of residents who remain housed at the facility. In particular, these conditions mean that social distancing is very difficult, if not impossible, to effectively implement.

15. I have also reviewed an excerpt of a declaration from Jacques Wilson, the brother of a resident, Lance Wilson housed in Unit F. In addition to some of the representations above, the declarant indicates that: (1) residents stand in line "for some time" in the lobby to receive meals and medications and during this they are unable to practice social distancing; (2) Wilson was informed on May 1 that he tested positive for COVID-19 and since that time has been experiencing migraines, body chills, and frequent sweating in his sleep, but has not had any treatment, monitoring, or access to a physician to discuss his prognosis or treatment options.

16. I cannot draw any conclusions from a single second-hand report. However, if these allegations were found to be accurate, and if they were found to be representative of the system of health care delivery operating at Terminal Island, I would likely draw the following conclusions: (1) Terminal Island operators are exposing residents to a significant risk of harm by ensuring that residents cannot socially distance; (2) The health care delivery system at Terminal Island is currently unable to provide minimally safe health care, *i.e.*, the current system poses a significant risk of serious harm to residents, a risk that will only increase as more residents become symptomatic from COVID-19 or the condition of symptomatic residents deteriorates as their disease progresses.

17. If the second conclusion above were true, I would need more information through discovery to determine the cause(s). However, based on my experience operating, evaluating, and monitoring correctional health care systems, it would likely be the result of one or more of the following factors: insufficient number of staff; inappropriate types of staff (for example, using licensed vocational nurses, performing beyond their licensed scope of practice, to carry out the duties of a registered nurse); insufficient training; and insufficient supervision. For these reasons, I recommend consideration of a concerted effort to downsize the population of Terminal Island to the lowest number possible immediately, with priority given to those at high risk of harm due to their age and health status. This will both allow

Terminal Island to implement more effective preventive and treatment measures while simultaneously granting released or transferred residents access to minimally acceptable living conditions. To maximize their effectiveness in reducing the spread and impact of the virus at Terminal Island, these downsizing measures must be implemented now.

18. There are two values to immediate downsizing. First, downsizing will reduce Terminal Island's density of congregation. This will allow people in prison to maintain better social distancing. The reduction in population will also make it easier for prison authorities to implement infection prevention measures such as: provision of cleaning supplies to residents; frequent laundering of towels and clothes; provision of soap for handwashing; frequent cleaning of transactional surfaces; etc. Furthermore, downsizing will allow prison health care professionals to devote their attention to a smaller number of residents, potentially improving the quality of care those residents receive. At any prison, but especially a Level 3 care facility like Terminal Island where residents with other underlying conditions requiring treatment are intentionally housed, it is beneficial to conserve medical resources in the face of a pandemic such as the one we presently face. All these steps can slow or stop the spread of infection (or re-infection) and improve treatment outcomes if they are currently inadequate, to the benefit of residents and staff and, ultimately, the community at large.

19. Second, immediate downsizing that prioritizes residents who are elderly and those with underlying health conditions reduces the likelihood they will contract the disease or suffer severe medical consequences as a result of being infected. Individuals in these groups are at the highest risk of severe complications from COVID-19 and when they develop severe complications they will be transported to community hospitals. Reducing the spread and severity of infection in a prison slows, if not reduces, the number of people who will become ill enough to require hospitalization where they will be using scarce community resources (ER

beds, general hospital beds, ICU beds) which also in turn reduces the health and economic burden to the local community at large. Indeed, in light of the new reality in which we operate, decisions to release residents from custody—traditionally concerned primarily with public safety—must also take into account the impact on public health. It is for this reason that release or transfer[1] of at-risk residents not only reduces their risk of death, but also increases public safety when the impact on public health is also considered.

20. Residents who have received confirmed diagnoses of COVID-19 in most cases may be safely released to the community, where they can quarantine or isolate at home. To the extent that the quality of care these residents currently receive is inadequate, release would also ensure that residents have access to better health care.

21. In addition to the downsizing described above, and to the extent they are not already being implemented, the following steps should immediately be mandated of the Respondents in order to protect any residents who remain in custody:

a. Social Distancing. The prison must ensure that residents are able to maintain adequate social distancing during required or necessary activities, such as collecting food, eating, and receiving medications.

b. Immediate and Continued Testing. Patients (both staff and residents) who require testing (or re-testing) based on public health recommendations and the opinion of a qualified medical professional, should be tested for COVID-19.

c. Immediate Screening. Defendants must be required to screen

[1] Transfer is only acceptable if the transfer itself does not pose significant risks and is a transfer to another facility where the quality of health care and COVID-19 precautions are safe.

each employee or other person entering the facility every day to detect fever over 100 degrees, cough, shortness of breath, other symptoms as currently recommended by CDC, and exposure to someone who is symptomatic or under surveillance for COVID-19, or screening as required by public health authorities. A record should be made of each screening.

d. Quarantine. The prison must establish non-punitive quarantine for all individuals believed to have been exposed to COVID-19, but not yet symptomatic, and non-punitive isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely inflicted with COVID-19 must utilize protective equipment as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the incarcerated population and each other.

e. Post-Isolation or Quarantine. Individuals should only be released from quarantine or isolation in accordance with CDC guidelines as modified by local public health authorities, after which they should be monitored in accordance with those same guidelines.

f. Institutional Hygiene. The prison must be required to provide adequate disinfection of all high-touch areas and cells.

g. Personal Hygiene. The prison must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis, free of charge, and ensure replacement products are available as needed. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol when they are in locations or activities where hand washing is not available. Correctional officers should be required to wear personal protective equipment and perform hand hygiene when appropriate, consistent with the CDC guidance as modified by local health authorities

h. Waive Copays. There must be a waiving of copays for medical evaluation and care related in any way to COVID-19 and/or its symptoms. A waiver of these types of copays is necessary to avoid disincentivizing patients from requesting medical treatment. Patients with symptoms of possible COVID-19 should be seen quickly.

i. Access to Care. All residents should have timely access to an appropriately qualified health care professional.

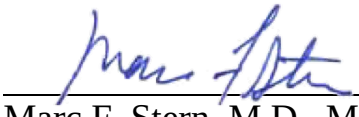
j. Personal Protective Equipment. Those residents with a cough should be provided masks as soon as they inform staff of this symptom or staff notice this symptom.

k. Supply Chain. The prison must be required to identify the supplies and other materials upon which the institution is dependent, such as food, medical supplies, certain medicines, cleaning products, etc., and prepare for shortages, delays or disruptions in the supply chain.

22. Thus, in summary, consideration should be given to immediately reducing the number of individuals imprisoned at Terminal Island immediately for the health and safety of the prisons and our communities, taking into account the *totality* of risk posed to the public safety by each individual. This population reduction should begin with the most medically vulnerable which includes those over age 50 and those with CDC-defined underlying health conditions.

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

Executed May 15, 2020, at Tumwater, Washington.



Marc F. Stern. M.D., M.P.H.

EXHIBIT A

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

May, 2020

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

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

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

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

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

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

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

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

Assistant Secretary for Health Services/Health Services Director, 2005 – 2008
Associate Deputy Secretary for Health Care, 2002 – 2005

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

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

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

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

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES **2001 – 2002**

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

CORRECTIONAL MEDICAL SERVICES, INC. (now CORIZON) **2000 – 2001**

Regional Medical Director, New York Region, 2000 – 2001

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

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

MERCY INTERNAL MEDICINE, ALBANY, NEW YORK **1999 – 2000**

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

ALBANY COUNTY CORRECTIONAL FACILITY, ALBANY, NEW YORK **1998 – 1999**

Acting Facility Medical Director, 1998 – 1999

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

VETERANS ADMINISTRATION MEDICAL CENTER, ALBANY, NY **1992 – 1998**

Assistant Chief, Medical Service, 1995 – 1998
Chief, Section of General Internal Medicine and Emergency Services, 1992 – 1998

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

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

ERIE COUNTY HEALTH DEPARTMENT, BUFFALO, NY **1988 – 1990**

Director of Sexually Transmitted Diseases (STD) Services, 1989 – 1990
Staff Physician, STD Clinic, 1988 – 1989
Staff Physician, Lackawanna Community Health Center, 1988 – 1990

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

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

Staff Physician, 1988 – 1990

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

VETERANS ADMINISTRATION MEDICAL CENTER, BUFFALO, NY **1985 – 1990**

Chief Outpatient Medical Section and Primary Care Clinic, 1986 – 1988
VA Section Head, Division of General Internal Medicine, University of Buffalo, 1986 – 1988

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

1973 – 1975	Instructor and Instructor Trainer of First Aid, American National Red Cross
1972 – 1975	Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.
1972 – 1975	Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

REVIEWER/EDITOR

2019 – present	Criminal Justice Review (reviewer)
2015 – present	PLOS ONE (reviewer)
2015 – present	Founding Editorial Board Member and Reviewer, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut
2011 – present	American Journal of Public Health (reviewer)
2010 – present	International Advisory Board Member and Reviewer, International Journal of Prison Health
2010 – present	Langeloth Foundation (grant reviewer)
2001 – present	Reviewer and Editorial Board Member (2009 – present), Journal of Correctional Health Care
2001 – 2004	Journal of General Internal Medicine (reviewer)
1996	Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine (reviewer)
1990 – 1992	Medical Care (reviewer)

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

2019 – present	Washington Association of Sheriffs and Police Chiefs
2005 – 2016	American Correctional Association/Washington Correctional Association
2004 – 2006	American College of Correctional Physicians (Member, Board of Directors, Chair Education Committee)
2000 – present	American College of Correctional Physicians

RECOGNITION

B. Jaye Anno Award for Excellence in Communication, National Commission on Correctional Health Care. 2019

Award of Appreciation, Washington Association of Sheriffs and Police Chiefs. 2018

Armond Start Award of Excellence, American College of Correctional Physicians. 2010

(First) Annual Preventive Medicine Faculty Excellence Award, New York State Preventive Medicine Residency Program, University at Albany School of Public Health/New York State Department of Health. 2010

Excellence in Education Award for excellence in clinical teaching, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington. 2004

Special Recognition for High Quality Workshop Presentation at Annual Meeting, Society of General Internal Medicine. 1996

Letter of Commendation, House Staff Teaching, University of Buffalo. 1986

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS/ABSTRACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXPERT TESTIMONY

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

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

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

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

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

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

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

EXHIBIT 7

DECLARATION OF PROFESSOR JUDITH RESNIK REGARDING ENLARGEMENT AND THE USE OF PROVISIONAL REMEDIES FOR DETAINED INDIVIDUALS

I have been asked to make this declaration to explain my understanding of the remedies, both provisional and permanent, that federal judges can provide to people who are incarcerated and facing the threat of COVID-19. Because I have practiced in the federal courts for decades and represented prisoners in federal court, I have had personal experience with the use of enlargement in habeas corpus cases. Given that this provisional remedy is not regularly discussed in reported decisions or in academic analyses, I believe that my experiences and knowledge can be useful to the Court. This opinion is mine and is not that of the institutions with which I am affiliated. I declare that the following is a true and accurate account of my own work as a lawyer, of the pertinent legal principles as I understand them, and of how these precepts can apply in this unprecedented context.

My Background

1. I have worked on occasion as a lawyer, including in the clinical programs at Yale Law School and at the University of Southern California Law Center (USC), where I taught for more than a decade before returning to Yale Law School. I have appeared before the United States Supreme Court and in federal district and appellate courts. I have also been appointed by federal judges to assist in issues arising in large-scale litigation. Below, I provide a few aspects of my work particularly relevant to this declaration. I attach my resume as Exhibit A to this Declaration.

2. From 1977 until 1980, I was a supervising attorney at Yale Law School's clinical program, which then provided legal services to federal prisoners housed at F.C.I. Danbury. From 1980 to 1996, I taught at USC in both traditional classroom and clinical settings.

3. I am now the Arthur Liman Professor of Law at Yale Law School where I teach courses, including on federal and state

courts; procedure; large-scale litigation; federalism; and incarceration.

4. I have taught law for decades. Much of my focus has been on the role and function of courts, and the relationship of governments to their populations. I regularly teach the class entitled Federal and State Courts in the Federal System. Readings for students include materials on habeas corpus and on civil rights litigation.

5. In 2018, I was awarded an Andrew Carnegie Fellowship to work on a book, tentatively entitled *Impermissible Punishments*, which explores the impact of the 1960s civil rights revolution on the kinds of punishments that governments can impose on people convicted of crimes. Central to this book is the role that access to courts played for people held in detention.

6. I am the Founding Director of the Arthur Liman Center for Public Interest Law. The Liman Center teaches classes yearly, convenes colloquia, does research projects, supports graduates of Yale Law School to work for one year in public interest organizations, and is an umbrella for undergraduate fellowships at eight institutions of higher education.

7. I write about the federal courts; adjudication and alternatives such as arbitration; habeas corpus and incarceration; class actions and multi-district litigation; the judicial role and courts' remedies; gender and equality; and about transnational aspects of these issues. In recent years, I have spent a good deal of time doing research related to prisons. I have helped to develop a series of reports that provide information nation-wide on the use of solitary confinement.

8. In February of 2019, I testified before the U.S. Commission on Civil Rights at its hearing on women in prison and co-authored a statement related to the isolation of many facilities for women, their needs for education and work training, and the discipline to which they are subjected. *See* Statement submitted for the record, *Women in Prison: Seeking Justice Behind Bars*, before the U.S. Commission on Civil Rights, March 22, 2019. The report, published a few months ago, references this testimony. See U.S. Commission on Civil Rights, *Women in Prison: Seeking Justice Behind Bars* (February 2020), available at https://www.usccr.gov/pubs/2020/02-26-Women-in-Prison.pdf.

Remedies Available in the Federal Courts:
Habeas Corpus, Civil Rights Litigation, and Enlargement

9. In light of my knowledge of the federal law of habeas corpus, state and federal court relations, procedure, and remedies, I have been asked by counsel for the petitioners/plaintiffs to address the range of responses available to judges presiding in cases that raise claims related to COVID-19. I have submitted a declaration akin to this one in a few other cases.

10. As I understand from public materials on the health risks of this disease, COVID-19 poses a deadly threat to the well-being and lives of people who contract this disease. To reduce the risk and spread of this disease, our governments have instructed us to stay distant from others and to take measures that are extraordinary departures from our daily lives and routines.

11. Applying these urgent medical directives to prisons poses challenges in every jurisdiction. Governing legal principles about prisoners' access to courts were not framed to address COVID-19's reality: that being inside prisons that are densely populated can put large numbers of people (prisoners and staff) at risk of immediate serious illness and potential death.

12. These unprecedented risks from and harms of COVID-19 in prison raise a new legal question: whether COVID-19 has turned sentences which, when imposed, were (or may have been) constitutional into unconstitutional sentences during the pendency of this crisis.

13. When sentencing people to a term of years of incarceration, judges had no authority to impose putting a person at grave risk of serious illness and death as part of the punishment for the offense. Now, such grave risks and harms can arise from the fact of incarceration.

14. A recent Supreme Court case, *Montgomery v. Louisiana*, 136 S.Ct. 718 (2016), provides an analogous situation of sentence that was constitutional at sentencing but unconstitutional now. The Court determined that, in light of new understandings of the limits of brain development in juveniles, sentences of life without parole (LWOP) imposed on individuals who had committed crimes when under the age of eighteen were lawful when issued but became unconstitutional. As a consequence, parole boards or courts had to reconsider whether LWOP remained appropriate. COVID-19 raises a parallel question, as it requires courts to address whether

sentences lawful at imposition can (at least temporarily) no longer be served in prisons because otherwise, the sentence would become an unconstitutional form of punishment. In these abnormal times, the speed at which decisions are made is critical. Therefore, as I discuss below, provisional remedies (enabling enlargement and release for some individuals and de-densifying for others) are necessary.

15. The classic and longstanding remedy for relief from unconstitutional detention, conviction, and sentences is habeas corpus. The Constitution enshrined the remedy of habeas corpus, which has a substantial common law history and is codified in federal statutes. *See generally* Paul D. Halliday, *Habeas Corpus* (Harvard U. Press, 2012); Amanda L. Tyler, *Habeas Corpus in Wartime* (Oxford U. Press, 2017); Randy Hertz and James Liebman, *Federal Habeas Corpus Practice and Procedure* (2 volumes, 2019); Hart & Wechsler, *The Federal Courts and the Federal System*, Chapter X1, 1193-1164 (Richard H. Fallon, Jr, John F. Manning, Daniel J. Meltzer & David Shapiro, 7th ed., 2015). These citations are the tip of a vast and substantial literature that aims to understand the history and law of habeas corpus.

The Legal Thicket

16. As is familiar, in federal courts, federal petitioners file under 28 U.S.C. §2255 (post-conviction motions) and under §2241 (the general habeas statute), both of which are civil actions.

17. For example, when I worked at Yale Law School in its clinical program in the late 1970s, we filed lawsuits for federal prisoners predicated on 28 U.S.C. §2241 as well as (in appropriate situations) on 28 U.S.C. §1331 (general question jurisdiction) and 28 U.S.C. §1361 (mandamus), and in several instances, we filed cases as class actions. In the mid-1970s, the Supreme Court provided rules and forms for §2254 and §2255 filings. The Federal Rules of Civil Procedure supplement those rules, as recognized in F.R.Civ.Pro. 81(a)(4).

18. Congress has recognized that federal judges are authorized under the habeas statutes to "summarily hear and determine the facts, and dispose of the matter as law and justice require." *See* 28 U.S.C. §2243. In addition to this statutory authority, federal judicial power is predicated on the constitutional protection of the writ and on the common law.

19. Congress has channeled and circumscribed some of federal judicial authority through the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA) and, relatedly, under the Prison Litigation Reform Act (PLRA) of 1996.

20. Moreover, the Supreme Court has issued many decisions interpreting the prior habeas statutes, the 1996 revisions in AEDPA, and the intersection of habeas and civil rights claims brought under 42 U.S.C. §1983. The result is a dense arena of law and doctrine that can be daunting for litigants and jurists alike.

21. Some Supreme Court decisions, written to address claims by state prisoners, have delineated litigation focused on the fact or duration of confinement, for which release is the remedy and habeas is the preferred route, from challenges to conditions of confinement, for which the Court has required use of 42 U.S.C. §1983. *See, e.g., Preiser v. Rodriguez*, 411 U.S. 475 (1978); *Heck v. Humphrey*, 512 U.S. 477 (1994). Yet that distinction is hard to apply, and many opinions have identified that the overlap, as exemplified by *Mohammad v. Close*, 540 U.S. 744 (2004), *Wilkinson v. Dotson*, 544 U.S. 74 (2005), and by other Supreme Court and lower court decisions.

22. COVID-19 poses a new and painful context in which to undertake that analysis. Some reported decisions addressing the constitutional right of prisoners that officials not be "deliberately indifferent to serious medical needs" consider those Eighth Amendment claims to be appropriate for §1983 because they relate to conditions. But this deadly disease turns ordinary conditions into potentially lethal threats of illness for which the remedy to consider is release of at least some prisoners because density puts people at medical risk.

23. Because COVID-19 can end people's lives unexpectedly and abruptly, COVID-19 claims turn the condition of being incarcerated into a practice that affects the fact or duration of confinement. In my view, COVID-19 claims, therefore, collapse the utility and purpose of drawing distinctions between what once could more coherently be distinguished.

24. Courts need also to consider how COVID-19 fits (or not) with provisions of AEDPA and the parameters of the PLRA. Again, new problems have emerged. For example, in some contexts for state and federal prisoners, a question of exhaustion of remedies arises. Often one issue is the ability of the executive branch to respond

quickly. In the COVID context, day by day, the risk of illness increases for prisoners and staff, which endanger health care resources. Exhaustion would be "futile" if other branches of government are not prompt in response and if people become sick, risks skyrocket, and deaths occur.

25. "Futility" thus needs to be analyzed in terms not only of the capacity of institutions but in terms of the likelihood that the people seeking relief will be well enough to have the capacity to do so, and that the remedy provided will be effective given the alleged harm.

26. Other legal issues include when class actions or other forms of multi-party treatment are appropriate and if so, whether the criteria such as those of Rule 23 are met; the merits of arguments about unconstitutional sentences and conditions; and the range of remedies. Furthermore, circuit case law varies somewhat on the use and application of the Federal Rules of Civil Procedure in habeas filings and on the scope and the interpretation of 28 U.S.C. §2241.

The Availability of Provisional Remedies

27. The reason to flag some of the many issues that litigation of both habeas petitions and civil rights cases entail is to underscore the importance of considering provisional remedies when cases are pending. In general, time is required for lawyers to brief and for judges to interpret and apply the law. But waiting days in a world of COVID infections can result in the loss of life.

28. While courts have not faced COVID before, they have faced urgent situations, which is why provisional legal remedies exist. Courts have two ways to preserve the *status quo* – which here means protecting to the extent possible the health of prisoners, staff, and providers of medical services. One route is the use of temporary restraining orders and preliminary injunctions. These remedies require no explanation because they are familiar procedures. *See* Fed. R. Civ. Pro. 65.

29. Another option is an aspect of federal judicial power that is less well known. District courts have authority when habeas petitions are pending to "enlarge" the custody of petitioners. "Enlargement" is a term that, as far as I am aware, is used only in the context of habeas. (More familiar terms for individuals permitted to leave detention are "release" and "bail," and some

decision that "enlarge" petitioners use those words rather than enlargement).

30. The distinction is that enlargement is not release. The person remains *in custody* - even as the place of custody is changed and thus "enlarged" from a particular prison to a hospital, half-way house, a person's home, or other setting. Enlargement is a provisional remedy that modifies custody by expanding the site in which it takes place.

31. Enlargement has special relevance when the PLRA has application. As I understand the PLRA's rules on the "release" of prisoners, enlargement would not apply, as enlargement is not a release order. And, of course, interpreting the many directives of the PLRA in light of COVID entails more elaboration that my comments here.

32. The need to work through that statute and case law is another reason why the availability of provisional remedies is so important. Enlargement provides an opportunity for increasing the safety of prisoners, staff, and their communities while judges consider a myriad of complex legal questions.

33. I first encountered the provisional remedy of enlargement in the 1970s, when I represented a prisoner – Robert Drayton – who was confined at F.C.I. Danbury and who filed a habeas petition alleging that the U.S. Parole Commission had unconstitutionally rescinded his parole.

34. The Honorable T.F. Gilroy Daly, a federal judge sitting in the District of Connecticut, granted Mr. Drayton's request for enlargement while the decision on the merits was pending. Mr. Drayton returned to his home in Philadelphia and came back to Connecticut for the merits hearing. Judge Daly thereafter ruled in his favor; that decision was upheld in part and reversed in part. *See Drayton v. U.S. Parole Commission*, 445 F. Supp. 305 (D. Conn. 1978), *affirmed in part*, *Drayton v. McCall*, 584 F.2d 1208 (2d Cir. 1978).

35. Judge Daly did not write a decision explaining the enlargement. Given that I knew that the use of enlargement was not always recorded in published decisions and that enlargement had special relevance here, I decided I should learn more about other courts' discussion of this provisional remedy.

36. The provisional district court remedy of enlargement is not mentioned directly in in federal rules governing the lower

federal courts. In contrast, at the appellate level, Federal Rule of Appellate Procedure (FRAP) 23 provides in part that:

> While a decision not to release a prisoner is under review, the court or judge rendering the decision, or the court of appeals, or the Supreme Court, or a judge or justice of either court, may order that the prisoner be: (1) detained in the custody from which release is sought; (2) detained in other appropriate custody; or (3) released on personal recognizance, with or without surety. While a decision ordering the release of a prisoner is under review, the prisoner must – unless the court or judge rendering the decision, or the court of appeals, or the Supreme Court, or a judge or justice of either court orders otherwise – be released on personal recognizance, with or without surety.

As that excerpt reflects, the Rule uses language familiar in the context of bail and provides that appellate courts may also determine that a petitioner be detained in "other appropriate custody."

37. Federal courts at all level are authorized by Congress to decide habeas cases "as law and justice requires." 28 U.S.C. §2243. The case law also references that, at the district court level, the authority to release a habeas petitioner pending a ruling on the merits stems from courts' inherent powers. *See, e.g.*, *Mapp v. Reno*, 241 F.3d 221, 226 (2d Cir. 2001). And, as I noted, in these reported decisions, the terms "bail" or "release" are sometimes used instead of or in addition to "enlargement."

38. In the last weeks, the saliency of enlargement has prompted me to review more of the law surrounding it. To gather materials and opinions on enlargement, I asked two law students, Kelsey Stimson of Yale Law School and Ally Daniels of Stanford Law School, to help me research what judges have said about enlargement and what others have written. Below I detail some of the governing case law. The Hertz & Liebman *Treatise on Habeas* also has a section (§14.2) devoted to this issue.

39. Some of the decisions involve requests for release when habeas petitions were pending from state prisoners, and others from federal prisoners, or from people in immigration detention. Further, several appellate cases address the issue of whether a district court order on enlargement was appealable as of right or subject to mandamus.

40. My central point is that, amidst these various debates about appealability and the test for enlargement/release, most circuits have recognized that district courts have the authority to order release pending final disposition of a habeas petition. *See e.g., Woodcock v. Donnelly*, 470 F.2d 93, 43 (1st Cir. 1972); *Mapp v. Reno*, 241 F.3d 221, 226 (2d Cir. 2001); *Landano v. Rafferty*, 970 F.2d 1230, 1239 (3d Cir. 1992); *Calley v. Callaway*, 496 F.2d 701, 702 (5th Cir. 1974); *Dotson v. Clark*, 900 F.2d 77, 79 (6th Cir. 1990); *Cherek v. United States*, 767 F.2d 335, 337 (7th Cir. 1985); *Martin v. Solem*, 801 F.2d 324, 329 (8th Cir. 1986); *Pfaff v. Wells*, 648 F.2d 689, 693 (10th Cir. 1981): *Baker v. Sard*, 420 F.2d 1342, 1342-44 (D.C. Cir. 1969).

41. The Fourth and Eleventh Circuits appear, albeit less directly, to recognize enlargement authority. *See Gomez v. United States*, 899 F.2d 1124, 1125 (11th Cir. 1990); *United States v. Perkins*, 53 F. App'x 667, 669 (4th Cir. 2002). A Ninth Circuit opinion from 1989 likewise appears to recognize the power of district courts to grant release pending a habeas decision where there are "special circumstances or a high probability of success." *See Land v. Deeds*, 878 F.2d 318 (9th Cir. 1989). Thereafter, another decision, *In re Roe*, described the Circuit as not having ruled on the issue in terms of state prisoners. *See* 257 F.3d 1077 (9th Cir. 2001).[1]

42. A discrete question is the standard for enlarging petitioners. To obtain an order for release pending the merits of habeas decision, the petitioner must demonstrate "extraordinary circumstances" and that the underlying claim raises "substantial claims." *See e.g. Mapp v. Reno*, 241 F.3d 221, 226 (2d Cir. 2001). Courts have also discussed that release is appropriate when "necessary to make the habeas remedy effective." *Mapp*, 241 F.3d at 226*; see also Landano v. Rafferty*, 970 F.2d 1230, 1239 (3d Cir. 1992). As that Third Circuit decision explained, release was "available 'only when the petitioner has raised substantial constitutional claims upon which he has a high probability of success, and also when extraordinary or exceptional circumstances

[1] Subsequent lower court cases debated whether district courts do possess such authority. *See, e.g., Hall v. San Francisco Sup. Ct.*, 2010 WL 890044, at *2 (N.D. Cal. Mar. 8, 2010) ("Based on the overwhelming authority [of other circuit courts] in support, the court concludes for purposes of the instant motion that it has the authority to release Hall pending a decision on the merits."); *United States v. Carreira*, 2016 U.S. Dist. LEXIS 31210, at *4, (D. Haw. Mar. 10, 2016) ("[T]his Court declines to address the merits of Petitioner's bail requests in the absence of definitive guidance from the Ninth Circuit regarding the scope of this Court's bail authority.").

exist which make the grant of bail necessary to make the habeas remedy effective.'"

43. Some judges have interpreted the "substantial questions" prong to require the underlying claim to have a "high probability of success." *See Hall v. San Francisco Superior Court*, No. C 09-5299 PJH, 2010 WL 890044, *1 (N.D. Cal. Mar. 8, 2010); *In re Souels*, 688 F. App'x 134, 135 (3d Cir. 2017). That test resembles standards for preliminary injunctive relief and for stays, which include an assessment of the likelihood of success on the merits and of whether the balance of hardships tips in favor of altering the status quo. (And, of course, more can be said about the nuances of these bodies of law as well.)

44. A few cases focus on the health of a petitioner as central to the conclusion that "extraordinary circumstances" exist. For example, in *Johnston v. Marsh*, the petitioner, Alfred Ackerman, brought a habeas claim alleging that he was convicted in Pennsylvania through a trial that lacked "due process." 227 F.2d 528 (3d Cir. 1955). Ackerman asked for release pending a decision on the merits of his habeas petition; he argued that he had advanced diabetes and was "rapidly progressing towards total blindness." *Id.* at 529. The district court authorized Ackerman to be released to a private hospital. The prison warden (Frank Johnston) went to the Third Circuit invoking sought writs of prohibition and mandamus to order the district court (Judge Marsh) to change his ruling. Rejecting the petitions, the Third Circuit affirmed that district courts possessed the authority to order relocation while the habeas petition was pending. *Johnson v. Marsh* has been cited in more recent cases to illustrate that findings of extraordinary circumstances may "be limited to situations involving poor health or the impending completion of the prisoner's sentence." *Landano*, 970 F.2d at 1239.

45. The court in *In re Souels* addressed what showing of health problems constituted extraordinary circumstances. *See* 688 F. App'x at 135-36. Sean Souels, who was serving a 46-month federal prison sentence, petitioned for a writ of mandamus directing the court to rule on his writ of habeas corpus and sought release pending the decision. *Id.* at 134. The court denied Souels bail because "he [did] not describe his medical conditions in any detail or explain how he cannot manage his health issues while he is in prison." *Id.*

46. Health is not the only extraordinary circumstance that has been the basis for enlargement. For example, in *United States v. Josiah*, William Josiah brought a writ of habeas corpus after

the Supreme Court invalidated the residual clause of the Armed Career Criminal Act (ACCA) and altered the method for determining whether prior convictions qualify as violent felonies under the ACCA. 2016 WL 1328101, at *2 (D. Haw. Apr. 5, 2016). Josiah, who was serving a federal prison sentence argued that his prior convictions did not qualify as violent felonies and that he should not be subject to the fifteen-year mandatory minimum. The district court concluded that because the issue of retroactivity was pending before the Supreme Court and Josiah would have served his full sentence if the Court held its prior ruling retroactive, release pending the higher court's ruling was appropriate. *Id.* at *4-6.

47. In circumstances similar to *Josiah*, a district judge sitting in the Central District of Illinois issued three orders granting release, termed bail, to petitioners pending resolution of their habeas claims. See *Zollicoffer v. United States*, No. 15-03337, 2017 WL 79636 (C.D. Ill. Jan. 9, 2017); *United States v. Jordan*, No. 04-20008, 2016 WL 6634852 (C.D. Ill. Nov. 9, 2016); *Swanson v. United States*, No. 15-03262, 2016 WL 5422048 (C.D. Ill. Sept. 28, 2016).

48. Another case involved enlargement in the context of the military. *See Gengler v. U.S. through its Dep't of Def. & Navy*, 2006 WL 3210020, at *6 (E.D. Cal. Nov. 3, 2006). As that court explained, a "district court has the inherent power to enlarge a petitioner on bond pending hearing and decision on his petition for writ of habeas corpus." *Id.* at *5. The judge also noted that a "greater showing must be made by a petitioner seeking bail in a criminal conviction habeas 'than would be required in a case where applicant had sought to attack by writ of habeas corpus an incarceration not resulting from a judicial determination of guilt.'" The court used the test of "exceptional circumstances and, at a minimum, substantial questions as to the merits." *Id.* at 13. The court found "exceptional circumstances" based on the fact that the petitioner had been admitted to business school, had been granted permission by his commanding officer to attend, and would be forced to drop out if his custody were not enlarged. The court also ruled that "substantial questions as to the merits" existed because of alleged government errors in drafting the petitioner's service agreement. *Id.* at *6.

49. As of this writing, a few reported cases discuss COVID-based requests for enlargement while a habeas corpus proceeding is pending. In addition, many decisions address requests for release under federal statutes as well as other remedies.

50. Given the fast pace of litigation and the many concerns about people's well-being, UCLA has created a website that is regularly updated and compiles materials and decisions related to COVID. See UCLA Law Covid-19 Behind Bars Data Project, *available at* https://docs.google.com/spreadsheets/d/1X6uJkXXS-O6eePLxw2e4JeRtM41uPZ2eRcOA_HkPVTk/edit#gid=708926660.

51. Below I provide a few illustrations of decisions since April that are related to COVID and enlargement.

52. On April 7, the Honorable Jesse Furman, sitting in the Southern District of New York, granted on consent a motion styled "for bail" (the term used in the Second Circuit *Mapp* decision). Judge Furman ordered immediate release under specified conditions, pending the adjudication of the Section 2255 Motion. *See United States v. Nkanga,* No. 18-CR-00730 (S.D.N.Y., Apr. 7, 2020).

53. A second case involves a class action filed by Craig Wilson and others. *See Wilson v. Williams*, No. 4:20-cv-00794-JG, 2020 WL 1940882, at *1 (N.D. Ohio Apr. 22, 2020). Seeking to represent a class of all current and future prisoners of the Elkton Federal Correctional Institution (FCI) and a subclass of the medically vulnerable population, they sought relief because their continued incarceration subjected all FCI prisoners to substantial risk of harm in violation of the Eighth Amendment.

54. On April 22, 2020, the federal district court granted in part the request by the *Wilson* class for emergency relief, which included enlargement of a subclass of prisoners challenging the manner in which the sentence was served and hence cognizable as a habeas petition. *See Wilson v. Williams*, No. 4:20-cv-00794-JG, 2020 WL 1940882 (N.D. Ohio Apr. 22, 2020). The Sixth Circuit denied a stay soon thereafter. *See Wilson v. Williams*, No. 4:20-CV-00794, 2020 WL 2308441, at *1 (6th Cir. May 8, 2020).

55. The *Wilson* case also cited to *Money v. Pritzker*, No. 1-20 CV 02094, 2020 WL 1920660, at *1 (N.D. Ill. April 10, 2020), a class action seeking relief on behalf of state prisoners, and the *Wilson* court referenced that I had also submitted a declaration similar to this one in that action. In *Money*, I discussed enlargement as well as the interaction between civil rights litigation and habeas corpus. *Id.* at *8–9. The Honorable Robert M. Dow, Jr. invoked my discussion, and the court determined not to grant the emergency relief sought by the plaintiff class. *Id.*

56. On May 12, 2020, the Honorable Michael Shea issued another decision responding to a petition challenging treatment of

prisoners at three facilities that compromise FCI Danbury. In *Martinez-Brooks v. Easter*, 3-20-cv-00569-MPS, 2020 WL 2405350 (D. Conn., May 12, 2020). Judge Shea granted in part the request for a temporary restraining order and required "the Warden at FCI Danbury to adopt a process for evaluating inmates with COVID-19 risk factors for home confinement and other forms of release that is both far more accelerated and more clearly focused on the critical issues of inmate and public safety than the current process." *Id.* at *1. He also ordered expedited discovery and scheduled a June hearing on the request for a preliminary injunction. *Id.* In that opinion, Judge Shea discussed enlargement as he analyzed the relief sought by the petitioners. *Id.* at *2

57. Another case has less relevance as it was brought by an unrepresented litigant, Richard Peterson, who had originally sought habeas corpus relief on a claim about education credits and then filed an emergency request for release from a California state prison due to COVID-19. *Peterson v. Diaz*, No. 2:19-CV-01480, 2020 WL 1640008, at *1 (E.D. Cal. Apr. 2, 2020). The district court noted that a class action raising COVID claims was pending in another federal court in California and that, while the court had the authority to release a person while a habeas petition was pending, Mr. Peterson had not provided evidence sufficient to meet the test to do so. *Id.*

Conclusion

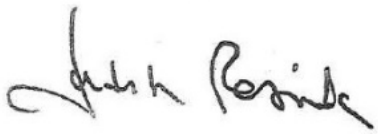
58. In sum, COVID-19 is an unprecedented event that, in my view, raises the legal question of whether, in light of the government mandates for social distancing, sentences (that had been lawful when they were imposed) cannot lawfully be served when the setting puts an individual in a position of untenable risk. Thus, habeas corpus – which addresses the constitutionality of sentences and offers the possibility of release and enlargement – properly provides a jurisdictional basis and remedies for this situation.

59. I need also to note that, in recent years, the Supreme Court has raised questions in many contexts about the remedial powers of federal judges. Whether the topic is nationwide injunctions or commercial contracts, debates have occurred within the Court about the authority of federal judges.

60. Those cases do not address the extraordinary and painful moment in which we are all living. Ordinary life has been up-ended in an effort to keep as many people as possible alive and not

debilitated by serious illness. Moreover, the Supreme Court opinions have not focused on the relevance of those remedial debates to situations were confinement can put entire staffs and detained populations at mortal risk. Therefore, judges have the obligation and the authority to interpret statutes and the Constitution to preserve the lives of people living in and working in prisons. It is my hope that this account of earlier uses of enlargement and the dense account of case law and doctrine will be of service to this Court and to the parties in understanding the meaning and import of American law.

Dated: May 14, 2020



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Employment

Arthur Liman Professor of Law, Yale Law School, 1997-present
Founding Director, Arthur Liman Center for Public Interest Law
Honorary Visiting Professor, University College London
Faculty of Law, 2009-2021
Visiting Professor, Dauphine Université Paris, March 2016
Visiting Professor, Université Panthéon-Assas Paris II, May 2015
Convening Professor, Constituting Federalism, a seminar for the Institute for Constitutional History in conjunction with the New York Historical Society, February 2014
Scholar in Residence, Columbia Law School, Spring 2011; 2012
Distinguished Visiting Professor, University of Toronto School of Law, 2005
Parsons Visitor, Sydney University School of Law, 2004

Visiting Professor, New York University School of Law, 1996-1997
Visiting Professor, Harvard Law School, Fall 1989
Visiting Professor, Yale Law School, Spring 1989
Visiting Professor, University of Chicago Law School, Fall 1988

Orrin B. Evans Professor of Law, University of Southern California, 1989-1997;
Professor of Law: 1985-1989; Associate Professor: 1982-1985;
Assistant Professor: 1980-1982
Member, Faculty, The Salzburg Seminar on U.S. Legal Institutions, July 1988

Acting Director, Daniel and Florence Guggenheim Program in Criminal Justice,
Yale Law School, 1979-1980

Lecturer in Law and Supervising Attorney, Yale Law School, 1977-1979

Instructor, New York University School of Law, 1976-1977

Law Clerk, Honorable Charles E. Stewart, United States District Court,
Southern District of New York, 1975-1976

Selected Professional Activities

Chair of Fellows Selection Committee and Founding Director, Arthur Liman Center for Public Interest Law, Yale Law School, 1997-present

Chair, Yale Law School Global Constitutionalism Seminar, A Part of the Gruber Program for Global Justice and Women's Rights, 2012-present
Member, Board of Managerial Trustees, International Association of Women Judges, 2001-present
Chair, Order of the Coif Book Award Committee, 2018-2020
Fellow, Whitney Humanities Center, 2020-2021
Chair, American Association of Law Schools, Section on Law and Humanities, 2020
Chair, American Association of Law Schools, Section on its Sections, 2019-2022
Advisor, American Law Institute, Project on Sexual and Gender-Based Misconduct on Campus, 2015-present
Member, Task Force on Federal Judicial Selection, Project on Government Oversight of The Constitution Project, 2019
Steering Committee, Women Faculty Forum, Yale University, 2001-present
Co-chair, 2001-2003, 2006-2008
Co-Chair, Judicial-Academic Network, National Association of Women Judges, 2009-2019, 1998-2001
Academic Fellow, Pound Civil Justice Institute, 2016-present
Fellow, Davenport College, Yale University, 2002-present
Former Chair, Section on Civil Procedure, American Association of Law Schools; 2018, 2003, 1991
Member, Executive Committee, Section on Federal Courts, American Association of Law Schools, 1999-2004, 2014-present; chair, 2002
Member, Executive Committee, Section on Law and the Humanities, American Association of Law Schools, 2015-present
Member, Academic & Scientific Council, The Gender Equality Project, Switzerland, 2009-present
Advisor, European Law Institute and International Institute for the Unification of Private Law Project, From Transnational Principles to Rules of European Civil Procedure, 2015-2016
Member, Executive Session, State Courts in the Twenty-First Century, The Kennedy School, Harvard University, 2008-2011
Member, Advisory Group, Principles of the Law of Aggregate Litigation, American Law Institute, 2004-2009
Member, Standing Committee on Federal Judicial Improvements, American Bar Association, 2006-2010 (prior three-year term in the late 1990s);
Chair, Academic Advisory Committee to the Standing Committee on Federal Judicial Improvements, American Bar Association, 2010-2014
Member, Editorial Board, Yale Journal of Law and Feminism
Member, Editorial Advisory Board, Yale Journal of Law and the Humanities
Member, Advisory Board, Journal of Law and Ethics of Human Rights
Member, Advisory Board, Litigation and Procedure, and Negotiation and Dispute Resolution eJournals (Social Science Research Network, online)
Member, Advisory Board, Women's Studies Quarterly

Other Activities

Co-chair of the Board, Fansler Foundation, 2003-2014
Member, National Board of Academic Advisors for the William H. Rehnquist Center on the Constitutional Structures of Government, 2007-2009
Member, Advisory Board of the Science for Judges Project, Brooklyn Law School, 2003-2007
Board Member, Lawyers' Committee for Civil Rights, 2004-2007
Liaison, American Association of Law Schools to the American Bar Association Commission on Women, 2000-2005
Member, Advisory Board of the Center for Judicial Process, Albany Law School, 2000-2004
Member, Editorial Board, Law and Social Inquiry, 1998-2004
Member, Committee on Diversity in Legal Education of the Section of Legal Education and Admissions to the Bar of the American Bar Association, 1996-2002
Consultant, RAND, Institute for Civil Justice, 1980-2002
Member, Editorial Board, The Justice System Journal
Member, Board of Governors, Society of American Law Teachers, 1980-1997
Co-Chair, University of Southern California Feminist Council, 1990-1996
Member, Ninth Circuit Gender Bias Task Force, 1990-1994
Co-Chair, Robert M. Cover Memorial Public Interest Retreat, Society of American Law Teachers, 1988-1992
Member of and a general reporter for the International Association of Procedural Law, 1991 Conference
Member, Planning Committee, ABA-AALS Conference on Women in Legal Education, 1990
Member, Advisory Panel to a Subcommittee of the Federal Courts Study Committee, 1989-1990
Member, Steering Committee for the Center for Feminist Research, University of Southern California, 1990-1994
Member, American Bar Association, Litigation Section, Federal Initiatives Task Force, 1991-1993
Chair, Section on Women in Legal Education, American Association of Law Schools, 1989
Member, Twentieth Century Fund Task Force on Judicial Responsibility, 1988-1989
Member, Board of ACLU of Southern California, 1985
Chair, Bryn Mawr College Centennial Campaign for Southern California, 1983-1985

Courses taught at Yale Law School, 1997-2020

Federal and State Courts in the Federal System
Procedure
Equality, Sovereignty and Citizenship (with Prof. Reva Siegel)
Gender: Globally and Locally (with Prof. Vicki Jackson)
Liman Workshops (topics and co-teachers vary yearly)
Rationing Law: Subsidizing Access to Justice in Democracies
Poverty and the Courts: Fines, Fees, Bail, and Collective Redress

Who Pays? Fines, Fees, Bail, and the Cost of Courts
Imprisoned
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Statement submitted for the record, Women in Detention: The Need for National Reform, Charles Colson Task Force on Federal Corrections Public Hearing, Washington, D.C., March 11, 2015

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Statement submitted for the record, Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, U.S. Senate, June 19, 2012

Courtroom Use: Access to Justice, Effective Judicial Administration and Courtroom Security, Hearing before the Subcommittee on Courts and Competition Policy of the United States Committee on the Judiciary, U.S. House of Representatives, September 24, 2010

Statement submitted for the record, Recommendations on Courthouse Construction, Courtroom Sharing and Enforcing Congressionally Authorized Limits on Size and Cost, Hearing before the Subcommittee on Economic Development, Public Buildings and Emergency Management Committee on Transportation and Infrastructure, U.S. House of Representatives, May 21, 2010

Statement submitted for the record, Sunshine in Litigation Act: Does Court Secrecy Undermine Public Health and Safety, Hearing before the Subcommittee on Antitrust, Competition Policy and Consumer Rights of the Committee on the Judiciary, 110th Cong. 181, December 11, 2007

Hearings on the Judicial Nomination of John G. Roberts, Jr., to be Chief Justice of the United States, held by the Committee on the Judiciary of the United States Senate, Washington, D.C., September 15, 2005

Hearings on the Judicial Selection before the Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness, held by the House of Commons, Ottawa, Canada, April 20, 2004

Hearings on the Proposed Amendments to Federal Rule of Civil Procedure 23, held by the Committee on Rules of Practice and Procedure, Judicial Conference of the United States, January 2002

Hearings on the Senate's Role in the Nomination and Confirmation Process: Whose Burden?, held by the Senate Committee on the Judiciary, Subcommittee on Administrative Oversight and the Courts, 107th Cong. , September 4, 2001, also published in 50 *Drake Law Review* 539 (2001-02)

Hearings on the Proposed Amendment to Federal Rule of Civil Procedure 23, held by the Committee on the Rules of Practice and Procedure, Advisory Committee to the Standing Committee on the Rules of Practice and Procedure of the United States Judicial Conference, November 1996

Hearings on the Proposed Long Range Plan of the Judicial Conference of the United States, held by the Committee on Long Range Planning, December 16, 1994

Hearings on the Proposed Changes in the Federal Rules of Civil Procedure, held by the Standing Committee on Rules of Practice and Procedure of the United States Judicial Conference, November 1991

Hearings on the Tentative Report of the Federal Courts Study Committee, held by members of the Committee, San Diego, California, January 29, 1990

Hearings on the Proposed Amendments to Rule 63 of the Federal Rules of Civil Procedure, held by the Advisory Committee to the Standing Committee on the Rules of Practice and Procedure of the United States Judicial Conference, January 1990

Hearings on the Confirmation of Robert H. Bork to be an Associate Justice of the United States Supreme Court, held by the Committee on the Judiciary, United States Senate, September 25, 1987

Hearings on Proposed Amendments to Rule 52(a) of the Federal Rules of Civil Procedure, held by the Subcommittee on Criminal Justice of the Judiciary Committee of the U.S. House of Representatives, June 26, 1985

Hearings on Proposed Amendments to Rule 68 of the Federal Rules of Civil Procedure, held by the Advisory Committee to the Standing Committee on the Rules of Practice and Procedure of the United States Judicial Conference, 1985

Hearings on Proposals to Amend the Rules Governing Section 2254 Cases in the United States District Courts, and Rules Governing Section 2255 Proceedings in the United States District Courts, held by the Advisory Committee to the Standing Committee on the Rules of Practice and Procedure of the United States Judicial Conference, 1984

Female Offender: 1979-80, Part 1: Hearings before the Subcommittee on Courts, Civil Liberties, and Administration of Justice of the House Committee. on Judiciary, 96th Cong. 59, October 11, 1979

Drug Abuse Treatment: Part 2: Hearings before the Select Committee on Narcotics Abuse and Control, House of Representatives, 96th Cong., July 25, 1978

Honors and Awards

Andrew Carnegie Fellowship, 2018-2020

Honorary Doctorate of Laws, University College London, 2018

Visiting Scholar, Max Planck Institute for Procedural Law, Luxembourg, February 2018

Establishment of the Resnik-Curtis Fellowship in Public Interest Law on the 20th anniversary of the Liman Program at Yale, 2017

Visiting Scholar, Phi Beta Kappa, 2014-2016

Recipient, Arabella Babb Mansfield Award, National Association of Women Lawyers, July 2013

Representing Justice: Invention, Controversy, and Rights in City-States and Democratic Courtrooms (with Dennis E. Curtis)
Selected as one of the "Best legal reads of 2011" by The Guardian
Recipient, SCRIBES Award from the American Society of Legal Writers, 2012
Recipient, PROSE Award, Excellence in Social Sciences, 2012
PROSE Award, Excellence in Law & Legal Studies, 2012

Selected as an Outstanding Academic Title of the Year by Choice Magazine, January 2012
Recipient, The Order of the Coif Biennial Book Award, January 2014

New York University Alumna of the Month Award, June 2012, http://www.law.nyu.edu/alumni/almo/pastalmos/2011-12almos/judithresnikjune

Elizabeth Hurlock Beckman Award, Awarded to Outstanding Faculty in Higher Education in the Fields of Psychology or Law, Columbia University, March 2011

Migrations and Mobilities: Citizenship, Borders, and Gender, Selected as an Outstanding Academic Title of the Year by Choice Magazine, January 2011

Outstanding Scholar of the Year Award 2008, from the Fellows of the American Bar Foundation

Oral History, 2007, Women Trailblazers in the Law Project, American Bar Association Commission on Women in the Profession, deposited in the Library of Congress, 2009

Convocation Speaker, Bryn Mawr College Commencement, May 2006

Member, American Philosophical Society, elected Spring 2002

Fellow, American Academy of Arts and Sciences, elected Spring 2001

Recipient, Margaret Brent Women Lawyers of Achievement Award, American Bar Association Commission on Women in the Profession, August 1998

Recipient, NYU School of Law, Legal Teaching Award, Spring 1995

Recipient, USC Associates Award for Creativity in Research, Spring 1994

Recipient, Florence K. Murray Award, National Association of Women Judges, Fall 1993

Recipient, "Big Splash Award" from the Program of Women and Men in Society (SWMS), University of Southern California, 1992

Member, Phi Kappa Phi, elected by the USC Chapter, 1991

University Scholar, University of Southern California, 1982-1983

Recipient, Student Bar Association Outstanding Faculty Award, University of Southern California Law Center, 1982-1983

Arthur Garfield Hays Fellow, 1974-1975, New York University

Education

Bryn Mawr College, B.A., cum laude, 1972
New York University School of Law, J.D., cum laude, 1975

Bar Memberships

Connecticut
United States District Courts: District of Connecticut, Southern District of New York, Eastern District of New York
United States Court of Appeals for the First, Second, Third, Fourth, Ninth and Eleventh Circuits
United States Supreme Court

Selected Litigation

United States Supreme Court

Of counsel on Brief of Amici Curiae, Law Professors in Support of Petitioners (No. 18-622), on Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit, Whole Woman's Health, et. al. v. Texas Catholic Conference of Bishops (2018) (on the question of standing)

Of counsel on Brief of Amici Curiae, Former Judges, Former Prosecutors, Former Government Officials, Law Professors, and Social Scientists in Support of Respondents (No. 17-312), United States of America v. Sanchez-Gomez 138 S.Ct. 1532 (2018) (on the use of shackles for defendants in federal court)

Of counsel on Brief of Amici Curiae, Professors of Federal Courts Jurisprudence, Constitutional Law, and Immigration Law in Support of Respondents (Nos. 16-1436 and 16-1540), Donald J. Trump, et al. v. International Refugee Assistance Project, et al, Donald J. Trump, et al. v. State of Hawaii, et al. (2017), 138 S.Ct. 2392 (2018) (on travel bans)

Of counsel on Brief of Amici Curiae, Constitutional Law, Federal Courts, Citizenship, and Remedies Scholars in Support of Respondent Luis Ramon Morales-Santana (No. 15-1191), Lynch v. Morales-Santana, 136 S.Ct. 2545 (2016) (on citizenship and gender)

Oral Argument and brief presented on behalf of the Respondent Norman Carpenter in Mohawk Industries, Inc. v. Carpenter (No. 08-678, 2009 WL 3169419) (argued October 5), 558 U.S. 100 (2009) (on appealability)

Of counsel on Brief of Law Professors as Amici Curiae, in Support of Respondent Jacob Denedo (No. 08-267, 2009 WL 418793), United States v. Denedo, 556 U.S. 904 (2009) (on jurisdiction)

Of counsel on Brief of Amici Curiae Professors of Constitutional Law and of Federal Jurisdiction, in Support of Petitioner Keith Haywood (No. 07-10374), Haywood v. Drown, 556 U.S. 729 (2009) (on state law and Section 1983)

Of counsel on Brief of Amici Curiae Professors of Constitutional Law and of the Federal Courts, in Support of the Habeas Petitioners Omar and Munaf (Nos. 07-394, 06-1666), Munaf v. Geren, 553 U.S. 674 (2008) (on the scope of habeas corpus)

Of counsel on Brief of Professors of Constitutional Law and of the Federal Jurisdiction as Amici Curiae, in Support of Petitioners Boumediene et al. (Nos. 06-394, 06-1196), Boumediene v. Bush, 553 U.S. 723 (2008) (on the scope of habeas corpus)

Brief of Amici Curiae Norman Dorsen, Frank Michelman, Burt Neuborne, Judith Resnik, and David Shapiro, in Support of Petitioner Salim Ahmed Hamdan (No. 05-184), Hamdan v. Rumsfeld, 548 U.S. 557 (2006) (on due process)

Brief of Amici Curiae of Law Professors in Support of Petitioner Paula Jones (No. 95-1853, 1996 WL48092), Clinton v. Jones, 520 U.S. 681 (1997) (on immunity)

Oral Argument presented on behalf of the Rotary Club of Duarte:
Board of Directors of Rotary International v. Rotary Club of Duarte, 481 U.S. 537 (1987) (on California public accommodations law and associational rights under the First Amendment)

United States Courts of Appeals

Brief of Amici Curiae, Scholars of the Law of Prisons, the Constitution, and the Federal Courts in Support of the Appellants (No. 16-4234), Delores Henry, et al., v. Melody Hulett, et al. (7th Cir, rehearing en banc pending, 2020) (on constitutional rights in prison)

Brief of Amici Curiae of Constitutional Law and Procedure Scholars Judith Resnik and Brian Soucek in Support of Petitioner (No. 16-73801), submitted for the hearing en banc, C.J.L.G. v. Jefferson B. Sessions III (9th Cir., , 880 F.3d 1122 (2019) (on due process, right to counsel, and immigrant children)

Of counsel on Brief of Amici Curiae, Professors of Federal Courts Jurisprudence, Constitutional Law, and Immigration Law in Support of Plaintiffs-Appellees, (No. 17-17168), Ninth Circuit, State of Hawaii, et al., v. Donald Trump (2017) (on travel bans)

Of counsel on Brief of Amici Curiae, Professors of Federal Courts Jurisprudence, Constitutional Law, and Immigration Law in Support of Plaintiffs-Appellees, (No.

17-2231 (L), 17-2232, 17-2233, 17-2240 (Consolidated)), Fourth Circuit, International Refugee Assistance Project, et al., Iranian Alliances Across Borders, et al., Eblal Zakzok, et al., v. Donald Trump (2017) (on travel bans)

Of counsel on Brief of Amici Curiae, Constitutional Law Professors in Support of Appellees and Affirmance (No. 17-1351), International Refugee Assistance Project et al. v. Donald J. Trump, et. al. (4th Cir. 2017) (on travel bans)

Appellate Counsel

In re San Juan Dupont Plaza Hotel Fire Litigation, 111 F.3d 220 (1st Cir. 1997) (on awards of fees and costs in a mass tort multi-district litigation)

In re Thirteen Appeals Arising Out of San Juan Dupont Plaza Hotel Fire Litigation, 56 F.3d 295 (1st Cir.1995)

In re Nineteen Appeals Arising Out of San Juan Dupont Plaza Hotel Fire Litigation, 982 F.2d 603 (1st Cir. 1992)

United States District Court

Declaration Regarding Provisional Remedies for Detained Individuals, Money v. Jeffries (N.D. Ill., Eastern Division, No. 20 cv 2-14, filed April 8, 2020

Of Counsel on Motion for Leave to File Declaration of Correctional Expert Rick Raemisch as Amicus Curiae, Savino et al. v. Hodgson et al. (D. Mass., No. 1:20-cv-10617-WGY, granted March 31, 2020) (to provide the court and parties with expert information)

Of Counsel on Unopposed Motion for Leave to File Amicus Curiae Statement of Correctional Expert Rick Raemisch, Coleman v. Newson (E.D. Cal, No. 2:90-CV-00520-KJM-DB 2020), Plata v. Newsom (No. C01-1351 JST, N.D. Cal., granted April 2, 2020) (to provide the court and parties with expert information)

Court-appointed trustee in re: MDL-926 Global Breast Implant Settlement, 173 F.Supp.2d 1381 (Judicial Panel on Multidistrict Litigation, N.D. Alabama, N.D. Texas, 1994) (overseeing the court-created "common benefit fund")

Expert appointed by the district court to assist the Special Master in McLendon v. Continental Group, Inc., 802 F.Supp. 1216 (D.N.J. 1992) (assisting the court in relationship to a settlement in an ERISA class action)

Exhibits, Co-Curator

The Remarkable Run of a Political Icon: Justice as a Sign of the Law. Rare Book Exhibition Gallery, Lillian Goldman Law Library, Yale Law School, September–December 2011 (with Dennis E. Curtis, Allison Tait & Michael Widener); http://library.law.yale.edu/justice-sign-law-exhibit

Courts: Representing and Contesting Ideologies of the Public Sphere. Yale Art Gallery, Study Galleries, January – May 2011 (with Dennis E. Curtis)

Selected Media

Interview, Women, Judging, Equality, and Constitutional Law, RAI Storia (Italian television) – *La Corte Costituzionale e le Donne, Pt. 6*, January 2020, https://vimeo.com/377835690

Interview, WNPR – Connecticut Public Radio's *Where We Live*, presented by John Dankosky, August 5, 2013; http://wnpr.org/post/connecticuts-criminal-justice-system

Interview, BBC Radio 4's *Law in Action*, presented by Joshua Rozenberg, March 12, 2013; http://www.bbc.co.uk/programmes/b01r5ln5

Cameo in *Fair Game*, directed by Doug Liman, Fall 2010, and
panel moderator, discussion of the film with Valerie Plame, Joseph Wilson, Emily Bazelon and Doug Liman, Paris Theatre, New York City, October 5, 2010

EXHIBIT 8

DECLARATION OF JIMMY THREATT

I, Jimmy Threatt, declare as follows:

1. I am an active member of the Bar of the State of California and an associate with Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, a professional corporation, attorneys of record for Petitioners in this action. Except for those matters stated on information and belief, I make this declaration based upon personal knowledge and, if called upon to do so, I could and would so testify.

2. I have attempted to arrange legal calls with four prisoners incarcerated at FCI Terminal Island who had been identified to my firm by their family members and friends as seeking our representation in this action. I have spoken with only one of them. None of the other calls have been scheduled by the Bureau of Prisons ("BOP"). Attached as **Exhibit A** is a compilation of true and correct copies of my email correspondence with BOP employees.

3. On May 9, 2020, I called the main desk at FCI Terminal Island to schedule a legal call with Lance Wilson, No. 72372-097. No one answered and I was not given the opportunity to leave a voice message.

4. On May 10, 2020, I again called the main desk at FCI Terminal Island to schedule a legal call with Lance Wilson. No one answered and I was not given the opportunity to leave a voice message.

5. Later that day, I emailed the publicly listed email address for FCI Terminal Island to schedule a call with Lance Wilson. I did not receive a response.

6. I then emailed the BOP Legal Department to schedule a call with Lance Wilson.

7. The next day, May 11, Eliezer Ben-Shmuel, an attorney with BOP, responded, instructing me to email the address for FCI Terminal Island that I had contacted on May 9 and 10.

8. Later on May 11, I received a call informing me that my request had been approved and a call with Lance Wilson would be scheduled for a later date.

I did not hear anything further until May 14.

9. On May 12, I emailed the address for FCI Terminal Island to schedule a legal call with William Sutton, Jr., No. 76176-112.

10. The following day, May 13, I called the main desk at FCI Terminal Island to follow up on my request for a call with William Sutton. No one answered and I was not given an opportunity to leave a message.

11. At 12:22 A.M. on May 14, I emailed FCI Terminal Island to schedule a legal call with Edgar Vasquez, No. 46907-007.

12. At 1:10 A.M. on May 14, I emailed FCI Terminal Island to schedule a legal call with Maurice Smith, No. 24299-298.

13. In the afternoon of May 14, I received an email from Jennifer Merkle, an attorney with BOP, informing me that she had been referred thirteen of my requests, which would include all of my requests for calls with prisoners at FCI Lompoc, USP Lompoc, and FCI Terminal Island. She stated she would need to assess every request individually and would be in touch as to each separately.

14. Later on May 14, I received a call from an officer at FCI Terminal Island instructing me that he was with prisoner Lance Wilson, who would be permitted to speak with me. I spoke with Mr. Wilson for approximately 15 minutes, during which time he relayed the following information:

- He has tested positive for COVID-19.
- He has underlying conditions of asthma and hypertension, for which he is prescribed medication. His symptoms have included body chills and severe migraines. He has not been placed into quarantine or isolated. He also has not received treatment or been granted access to doctors. When he has asked corrections officers for assistance, they have told him they would "call somebody" if he could no longer stand up but otherwise he would not be given any help.

- He has not seen or heard of any prisoners being tested again since the facility-wide testing occurred. He has heard of some prisoners being taken to the hospital. One person in his unit was taken to the hospital after suffering chronic diarrhea and body chills. However, he never came back, so Mr. Wilson does not know what happened to him.
- He has not received a new mask in over two weeks.

15. On May 14, 2020, I received an email from an officer confirming that the requests to schedule calls with prisoners Lance Wilson, William Sutton, and Maurice Smith had been received and instructing me that I should contact him to arrange for legal calls for those prisoners. I responded the same day to notify him that I had also submitted a request for a legal call with Edgar Vasquez. I have not heard back.

16. As I was finalizing this declaration on May 15, I received a second email from Ms. Merkle, asking me to call her so that she and I could "identify [my] specific needs."

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I executed this declaration on May 15, 2020, at Los Angeles, California.

Jimmy Threatt

EXHIBIT A

From: Jimmy Threatt
Sent: Sunday, May 10, 2020 11:12 AM
To: TRM/ExecAssistant@bop.gov
Cc: Naeun Rim
Subject: Legal Call with Inmate at FCI Terminal Island

Importance: High

My firm is counsel for Lance Wilson (Inmate No. 72372-097). I have been trying to schedule a call to discuss a legal matter with him. I have twice called to speak with his unit manager but have not heard back.

I would appreciate any assistance you can provide in setting up a call with Mr. Wilson. You can reach me at this email address or on my cell phone,

Thank you.

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, P.C.
1875 Century Park East, 23rd Floor
Los Angeles, California 90067-2561
www.BirdMarella.com

From: Jimmy Threatt
Sent: Monday, May 11, 2020 12:52 PM
To: Eliezer Ben-Shmuel
Cc: Naeun Rim
Subject: RE: Legal Call with Inmate at FCI Terminal Island

Thank you, Mr. Ben-Shmuel. I have already contacted the TRM/ExecAssistant email address but have not heard back. Do you know how long it typically takes to receive a response from that address? Is there anyone else I could contact?

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, P.C.
1875 Century Park East, 23rd Floor
Los Angeles, California 90067-2561
www.BirdMarella.com

From: Eliezer Ben-Shmuel <eben-shmuel@bop.gov>
Sent: Monday, May 11, 2020 11:14 AM
To: Jimmy Threatt <jthreatt@birdmarella.com>
Cc: Naeun Rim <nrim@birdmarella.com>
Subject: Re: Legal Call with Inmate at FCI Terminal Island

Mr. Threatt,

All requests for legal calls should be sent to TRM/ExecAssistant@bop.gov.

Please keep in mind that the institution needs to take significant precautions before permitting inmates to make these calls because of the significant potential for transmitting COVID-19 through telephone receivers. As a result, we appreciate your continued patience in setting up these calls.

Eliezer Ben-Shmuel
Supervisory Attorney
Los Angeles CLC
535 N. Alameda Avenue
Los Angeles, CA 90012
tel: (213) 485-0439 ext. 5428
fax: (213) 253-9505

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>>> Jimmy Threatt <jthreatt@birdmarella.com> 5/10/2020 6:26 PM >>>
My firm is counsel for Lance Wilson, an inmate housed at FCI Terminal Island (No. 72372-097). I have been trying to schedule a call to discuss a legal matter with him. I have twice called to speak with his unit manager and have also emailed the warden but I have not heard back from either of them.

I would appreciate any assistance you can provide in setting up a call with Mr. Wilson. You can reach me at this email address or on my cell phone,

Thank you.

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, P.C.
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From: Jimmy Threatt
Sent: Tuesday, May 12, 2020 8:29 PM
To: TRM/ExecAssistant@bop.gov
Cc: Christopher J. Lee; Naeun Rim
Subject: Legal Call with Inmate at FCI Terminal Island

Importance: High

I am writing to schedule a legal call with William Lewis Sutton, Jr. (Inmate No. 76176-112). I need to discuss an urgent legal matter with him. We called the facility this morning, but no one is answering the phone.

We would appreciate any assistance you can provide. You can reach me at this email address or on my cell phone, . If I am unavailable, you can also reach my colleagues (copied here): Christopher Lee at and Naeun Rim at

Thank you.

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
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Los Angeles, California 90067-2561
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From: Jimmy Threatt
Sent: Thursday, May 14, 2020 12:23 AM
To: TRM/ExecAssistant@bop.gov
Cc: Christopher J. Lee; Naeun Rim
Subject: Legal Call with Inmate at FCI Terminal Island

I am writing to schedule a legal call with Edgar Vasquez (Inmate No. 46907-007). This is a legal call regarding release options given the COVID crisis, and is urgent given that crisis.

We would appreciate any assistance you can provide. You can reach me at this email address or on my cell phone, . If I am unavailable, you can also reach my colleagues (copied here): Christopher Lee at and Naeun Rim at

Thank you.

Jimmy Threatt
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F: 310.201.2110
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From: Jimmy Threatt
Sent: Thursday, May 14, 2020 1:10 AM
To: TRM/ExecAssistant@bop.gov
Cc: Christopher J. Lee; Naeun Rim
Subject: Legal Call with Inmate at Terminal Island

I am writing to schedule a legal call with Maurice Smith (Inmate No. 24299-298). This is a legal call regarding release options given the COVID crisis, and is urgent given that crisis.

We would appreciate any assistance you can provide. You can reach me at this email address or on my cell phone, If I am unavailable, you can also reach my colleagues (copied here): Christopher Lee at and Naeun Rim at

Thank you.

Jimmy Threatt
Associate
T: 310.201.2100
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From: Jennifer Merkle <jmmerkle@bop.gov>
Sent: Thursday, May 14, 2020 1:04 PM
To: Jimmy Threatt
Subject: Requests for Legal Calls with Clients / Prospective Clients at FCC Lompoc

Good afternoon,

I think you may recall we spoke on the phone about a legal call for inmate Ben the other day. I have now been assigned 13 of your requests to review. It has become apparent that some of the individuals that you seek to have a legal call with are represented by other counsel as to their release options; therefore, I will be assessing each of these requests individually.

In the meantime, please feel free to send any additional request to me directly for review.

I will be in touch as to each request separately.

Thank you,
Jennifer

Jennifer M. Merkle
Senior Attorney
FCC Victorville
PO Box 5400
Adelanto, CA 92301
Phone: 760-530-5440
Fax: 760-530-5103
jennifer.merkle@usdoj.gov
jmmerkle@bop.gov

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From: John LeMaster <jlemaster@bop.gov>
Sent: Thursday, May 14, 2020 4:44 PM
To: Jimmy Threatt
Subject: Re: Legal Calls with Inmate at Terminal Island

Mr. Threatt,

Nice to talk with you today, as we discussed both you and your team may contact me to arrange legal calls for the inmates at Terminal Island. Please note in our response to COVID-19 we are running a modified operations schedule and I ask you provide me with a good contact number and as broad a range of time as to when my staff may facilitate the call. In reviewing the general mailbox I note you wish to contact the following inmates:

1. Maurice Smith (Inmate No. 24299-298);
2. Lance Wilson (Inmate No. 72372-097);
3. William Sutton Jr, (Inmate No. 76176-112).

Are there any other inmates you or your need me to make arrangements for?

J

John T. LeMaster
Senior Counsel
FCI Terminal Island
1299 Seaside Ave
San Pedro CA 90731
john.t.lemaster@usdoj.gov

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>>> On 5/14/2020 at 01:10, in message <F7B98A5D.0CF : 254 : 4302>, Jimmy Threatt <jthreatt@birdmarella.com> wrote:

I am writing to schedule a legal call with Maurice Smith (Inmate No. 24299-298). This is a legal call regarding release options given the COVID crisis, and is urgent given that crisis.

We would appreciate any assistance you can provide. You can reach me at this email address or on my cell phone, . If I am unavailable, you can also reach my colleagues (copied here): Christopher Lee at and Naeun Rim at .

Thank you.

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
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Los Angeles, California 90067-2561
www.BirdMarella.com

From: Jimmy Threatt
Sent: Thursday, May 14, 2020 5:18 PM
To: John LeMaster
Cc: Naeun Rim
Subject: RE: Legal Calls with Inmate at Terminal Island

Thank you, John. We also have a pending request to speak with Edgar Vasquez, Inmate No. 46907-007. My contact number is . We also have requests to speak with 8 inmates who are not housed at Terminal island – is it right that you can't help me with those?

Best,
Jimmy

Jimmy Threatt
Associate
T: 310.201.2100
F: 310.201.2110
E: jthreatt@birdmarella.com
Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow, P.C.
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Los Angeles, California 90067-2561
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From: John LeMaster <jlemaster@bop.gov>
Sent: Thursday, May 14, 2020 4:44 PM
To: Jimmy Threatt <jthreatt@birdmarella.com>
Subject: Re: Legal Calls with Inmate at Terminal Island

Mr. Threatt,

Nice to talk with you today, as we discussed both you and your team may contact me to arrange legal calls for the inmates at Terminal Island. Please note in our response to COVID-19 we are running a modified operations schedule and I ask you provide me with a good contact number and as broad a range of time as to when my staff may facilitate the call. In reviewing the general mailbox I note you wish to contact the following inmates:

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Are there any other inmates you or your need me to make arrangements for?

J

John T. LeMaster
Senior Counsel
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john.t.lemaster@usdoj.gov

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From: Jennifer Merkle <jmmerkle@bop.gov>
Sent: Friday, May 15, 2020 1:51 PM
To: Jimmy Threatt
Subject: Re: Requests for Legal Calls with Clients / Prospective Clients at FCC Lompoc

Good afternoon,

I have had a chance to go through all of the emails and research the cases for each of the individuals you are seeking to speak with. Please call me at your convenience so we can over these and identify your specific needs.

Jennifer

Jennifer M. Merkle
Senior Attorney
FCC Victorville
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Phone: 760-530-5440
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>>> Jennifer Merkle 5/14/2020 1:03 PM >>>
Good afternoon,

I think you may recall we spoke on the phone about a legal call for inmate Ben the other day. I have now been assigned 13 of your requests to review. It has become apparent that some of the individuals that you seek to have a legal call with are represented by other counsel as to their release options; therefore, I will be assessing each of these requests individually.

In the meantime, please feel free to send any additional request to me directly for review.

I will be in touch as to each request separately.

Thank you,
Jennifer

Jennifer M. Merkle
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