

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION**

BRITTANY WADDELL, ROGER EWING,
TONY SMITH, DANIEL HATTEN, DOUGLASS
TRIPLETT, ERIK LEWIS, BOB HENDERSON,
THOMAS HOLDER, and JAMARCUS DAVIS,
individually and on behalf of a class of all others
similarly situated,

Plaintiffs,

v.

TOMMY TAYLOR, in his official capacity as
Interim Commissioner of the Mississippi
Department of Corrections; RON KING, in his
official capacity as Superintendent of Central
Mississippi Correctional Facility; and JOE
ERRINGTON, in his official capacity as
Superintendent of South Mississippi Correctional
Institution,

Defendants.

Civil Action No. 3:20-cv-340-TSL-RHW

ORAL ARGUMENT REQUESTED

**PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION**

1. Plaintiffs respectfully request that the Court enter a temporary restraining order and preliminary injunction requiring the Defendants to effectively implement COVID-19 prevention and management protocols consistent with established standards of care for infection control and CDC guidelines. Pursuant to Local Rule 7(b)(6)(A), Plaintiffs respectfully request oral argument on this motion.

2. The Plaintiffs, who have brought this action on behalf of themselves and others similarly situated, are Brittany Waddell, Roger Ewing, Tony Smith, Daniel Hatten, Douglass Triplett, Erik Lewis, Bob Henderson, Thomas Holder, and Jamarcus Davis. They are residents of Mississippi's two largest prisons, Central Mississippi Correctional Facility (CMCF) and South Mississippi Correctional Institution (SMCI), home to nearly 6,000 residents, combined.¹

3. The Plaintiffs have brought this action under federal disability and constitutional law challenging MDOC's inadequate response to the COVID-19 pandemic. In violation of the Eighth Amendment of the Constitution, MDOC is aware of the high risk of serious harm its failures entail and has knowingly created a substantial risk of preventable illness, hospitalization, and death to residents, as well as facility staff and members of surrounding communities. In violation of federal disability law, MDOC has failed to make reasonable modifications to their procedures to protect individuals who suffer from disabilities that make it more likely they will succumb to rapid disease progression and death due to COVID-19 infection.²

¹ Defendants are the Interim Commissioner of the Mississippi Department of Corrections (MDOC) and Superintendents of CMCF and SMCI (collectively Defendants or MDOC).

² See Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 (prohibiting public entities from discriminating against qualified persons with disabilities in providing services); Section 504 of the Rehabilitation Act (RA), 29 U.S.C. § 794(a) (prohibiting recipients of federal funds from discriminating against qualified persons with disabilities). These laws require MDOC to make reasonable modifications to their policies, practices, and procedures to prevent unnecessary harm to qualified individuals with disabilities whose disabilities place them at substantially increased risk of serious illness and death due to COVID-19 infection.

4. The Plaintiffs therefore move for a temporary restraining order and a preliminary injunction requiring the Defendants to implement at CMCF and SMCI measures required by law to prevent irreparable harm to Plaintiffs, including but not limited to the following:

- a. Implement a facility-wide protocol, and effectively train residents and staff to use it, whereby a resident with coronavirus symptoms can report their symptoms and be evaluated by medical staff promptly; this method must work even if there is no security staff present on a zone or in the tower; sick call requests should result in a medical assessment as soon as possible but never longer than twenty-four hours after the resident's first attempt to initiate the sick call process;
- b. Conduct immediate testing for anyone displaying known symptoms of COVID-19;
- c. Identify high-risk patients using CDC criteria, offer them testing for COVID-19, and provide them the option of being placed into housing areas with increased levels of infection control and twice daily symptom and sign checks;
- d. Institute an active surveillance program to screen every inmate for signs and symptoms of COVID-19 on a daily basis;
- e. Inform all incarcerated people of the waiver of all medical co-pays for individuals experiencing possible COVID-19 symptoms;
- f. Implement daily temperature checks in housing units where COVID-19 cases have been identified;
- g. Implement intensified cleaning and disinfecting procedures and ensure that, several times per day, cleaning and disinfecting occurs of surfaces and objects that are frequently touched, especially in common areas;
- h. Ensure that each incarcerated individual receives a free and adequate personal supply of: hand soap that does not cause skin irritation and which is sufficient to permit frequent hand washing, paper towels, facial tissues, cleaning implements such as sponges or brushes, and disinfectant products that are effective against COVID-19; also provide no-touch trash receptacles for disposal of paper products;
- i. Implement a facility-wide protocol, and effectively train residents and staff to use it, whereby a resident who runs out of soap can obtain more promptly;

- j. Provide incarcerated individuals with sufficient and effective cleaning supplies free of charge so that they may clean frequently touched items, such as phones, before use;
- k. Ensure that all individuals have access to hand sanitizer containing at least 60% alcohol;
- l. Require that all CMCf and SMCI staff wear PPE consistent with the CDC Guidance, including masks and gloves, when interacting with visitors and incarcerated individuals or when touching surfaces in common areas; do not disallow residents from using PPE and educate residents on its effective use;
- m. Ensure incarcerated people are provided guidance on how to protect themselves from COVID-19 and reduce COVID-19 transmission; provide such guidance in English and in the primary language of others housed in MDOC, including Spanish;
- n. Provide frequent communication to all incarcerated individuals regarding COVID-19, measures taken to reduce the risk of infection, best practices for incarcerated people to avoid infection, and any changes in policies or practices;
- o. Provide an anonymous mechanism for incarcerated individuals to report staff who violate these guidelines so that appropriate corrective action may be taken;
- p. Inform incarcerated people that they will not be retaliated against for reporting COVID-19 symptoms or for reporting lack of compliance with COVID-19 mitigation measures;
- q. Ensure that incarcerated individuals can remain six feet apart to practice social distancing in compliance with CDC Guidance;
- r. Appoint an independent monitor with medical expertise to ensure compliance with these conditions, and provide the monitor with unfettered access to staff and to policies, procedures, and documents created to implement COVID-19 response procedures, as well as the ability to enter facility medical and housing units and have confidential communication with, and obtain video surveillance of, residents at any location in which they are being held;
- s. Provide Plaintiffs' counsel with unfettered access to the same documents, places, and people, minus staff.

In support of this motion, the Plaintiffs submit the exhibits listed below and are filing separately a memorandum setting forth the reasons why it should be granted.

- Exhibit 1:** Expert Report of Gregg Gonsalves (May 14, 2020)
- Exhibit 2:** Expert Report of Homer Venters (May 24, 2020)
- Exhibit 3:** Declaration of Jamarcus Davis (May 6, 2020)
- Exhibit 4:** Declaration of Roger Ewing (May 6, 2020)
- Exhibit 5:** Declaration of Daniel Hatten (April 30, 2020)
- Exhibit 6:** Declaration of Bob Henderson (May 6, 2020)
- Exhibit 7:** Declaration of Thomas Holder (May 8, 2020)
- Exhibit 8:** Declaration of Oziel Guzman (May 8, 2020)
- Exhibit 9:** Declaration of Derrick Guyton (May 11, 2020)
- Exhibit 10:** Declaration of Erik Lewis (May 7, 2020)
- Exhibit 11:** Declaration of Douglass Triplett (May 12, 2020)
- Exhibit 12:** Declaration Brent Ryan (May 8, 2020)
- Exhibit 13:** Declaration of Tony Smith (May 6, 2020)
- Exhibit 14:** Declaration of Brittany Waddell (May 13, 2020)
- Exhibit 15:** COVID-19 Questions and Answers, MDOC (May 21, 2020)

Dated: May 25, 2020

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EXHIBIT 1

**IN THE UNITED STATES DISTRICT COURT
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DECLARATION OF GREGG S. GONSALVES

I, **Gregg S. Gonsalves**, upon my personal knowledge, and in accordance with 28 U.S.C. § 1746, declare as follows:

1. I am an epidemiologist at the Yale School of Medicine and School of Public Health. I have worked at the schools of medicine and public health since 2017. Attached as Appendix 1 is my CV.
2. COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a virus closely related to the SARS virus. In its least serious form, COVID-19 can cause illness including fever, cough, and shortness of breath. However, for individuals who become more seriously ill, a common complication is bilateral interstitial pneumonia, which causes partial or total collapse of the lung alveoli, making it difficult or impossible for patients to breathe. Thousands of patients have required hospital-grade respirators, and COVID-19 can progress from a fever to

life-threatening pneumonia with what are known as “ground-glass opacities,” a lung abnormality that inhibits breathing.

3. In about 14% of cases of COVID-19, illness is severe including dyspnea, hypoxia, or >50 percent lung involvement on imaging within 24 to 48 hours.¹ Critical disease with respiratory failure, shock, or multiorgan dysfunction was reported in 5%. Among hospitalized patients, the proportion of critical or fatal disease is higher. In a study that included 2634 patients who had been hospitalized for COVID-19 in the New York City area, 14% were treated in the intensive care unit and 12% received invasive mechanical ventilation, and mortality among those receiving mechanical ventilation was 88%.
4. Certain populations of people are at particular risk of contracting severe cases of COVID-19. People over the age of fifty are at higher risk, with those over seventy at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, blood disorders, chronic liver or kidney disease, inherited metabolic disorders, developmental delays, those who are immunocompromised (such as from cancer, HIV, autoimmune diseases), those who have survived strokes, and those who are pregnant.²
5. There is no vaccine against COVID-19 and no vaccine is expected to be available until mid-2021 at the earliest. The new treatment for COVID-19, remdesivir, is thought to have only small to modest effects on time to recovery, and no effect on survival, which means almost all patients who develop severe disease, particularly those who require mechanical ventilation, face a high probability of death. The only known effective measures to prevent injuries or deaths resulting from COVID-19 are to prevent individuals from being infected with the virus. In fact, young and healthy individuals may be more susceptible than originally thought. Data from the CDC show that up to one-fifth of infected people ages 20-44 have been hospitalized, including 2%-4% in that age group that were treated in an intensive care unit.³
6. The number of people infected is growing exponentially. As of May 13, 2020, nearly 4.2 million people have been diagnosed globally with coronavirus, and more than 285,000

¹ Wu Z, McGoogan JM, JAMA *Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention* (2020); see also Richardson S, Hirsch JS, JAMA, Narasimhan M, et al. *Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area* (2020); Myers LC, Parodi SM, Escobar GJ, Liu VX, JAMA, *Characteristics of Hospitalized Adults With COVID-19 in an Integrated Health Care System in California* (2020).

² See Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): People Who May Be at Higher Risk*, <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html> (last accessed Mar. 18, 2020).

³ Sharon Begley, *New Analysis Breaks Down Age-Group Risk for Coronavirus — and Shows Millennials Are Not Invincible*, (March 18, 2020), <https://www.statnews.com/2020/03/18/coronavirus-new-age-analysis-of-risk-confirms-young-adults-not-invincible/>; Centers for Disease Control and Prevention, *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* (Mar. 26, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w/.

people have died as a result.⁴ Fifty states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have confirmed positive tests.⁵ As of May 13, the United States has had over 1.3 million confirmed cases, and over 82,000 Americans have died.⁶ This staggering death toll is almost twice what it was less than four weeks ago.⁷ The likely number of total deaths so far, confirmed and unconfirmed, is likely to be still higher and approximately 100,000.⁸ Thus more Americans have now died from COVID-19 than all who died in the Vietnam and Korean Wars combined.⁹ Experts predict that this rapid growth will continue in the United States.

7. For all people, even in advanced countries with very effective health care systems, the case fatality rate of COVID-19 is about ten-fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection. In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.
8. Based on data collected by the Centers for Disease Control and Prevention, World Health Organization, and National Center for Biotechnology Information on the speed at which SARS-CoV-2 has spread since it is first known to have infected a human in November 2019, the virus is estimated to be twice as contagious as influenza.¹⁰ Unlike influenza, there are no known vaccines or antiviral medications to prevent or treat infection from COVID-19. Because the coronavirus that causes COVID-19 is passed through respiratory droplets and also appears to be able to survive on inanimate surfaces, it can be transmitted even when an infected person is no longer in the immediate vicinity. Data from China indicate that the average infected person passes the virus on to 2-3 other people at distances of 3-6 feet.¹¹ Everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus.

⁴ WHO Coronavirus Disease (COVID-19 Dashboard), World Health Org., <https://covid19.who.int/> (last visited May 13, 2020).

⁵ Centers for Disease Control and Prevention, *COVID-19: U.S. at a Glance*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html (last accessed Apr. 20, 2020).

⁶ Coronavirus Disease 2019 (COVID-19): Covid-19 in the U.S., Centers for Disease Control and Protection, available at <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html> (last visited May 13, 2020).

⁷ *Id.* (Approximately 37,000 American had died of COVID-19 as of April 19, 2020).

⁸ *Excess Deaths Associated with COVID-19*, Centers for Disease Control and Prevention (2020), https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#dashboard; Nicholas Kristof, *America's True Covid Toll Already Exceeds 100,000*, N.Y. Times (May 13, 2020), <https://www.nytimes.com/2020/05/13/opinion/coronavirus-us-deaths.html>.

⁹ Nina Storchlic, *U.S. Coronavirus Deaths Now Surpass Fatalities in the Vietnam War*, Nat. Geographic (April 28, 2020), <https://www.nationalgeographic.com/history/2020/04/coronavirus-death-toll-vietnam-war-cvd/#close>.

¹⁰ Brian Resnick & Christina Animashaun, *Why Covid-19 Is Worse than the Flu, in One Chart*, Vox (Mar. 18, 2020), <https://www.vox.com/science-and-health/2020/3/18/21184992/coronavirus-covid-19-flu-comparison-chart>.

¹¹ Knvul Sheikh, Derek Watkins, Jin Wu & Mika Gröndahl, *How Bad Will the Coronavirus Outbreak Get? Here are 6 Key Factors*, N.Y. Times (Feb. 28, 2020), <https://www.nytimes.com/interactive/2020/world/asia/china-coronavirus-contain.html>.

9. The current estimated incubation period of COVID-19 is between 2 and 14 days, meaning that a patient who begins showing symptoms today may have been contagious for as long as two weeks prior. The time course of the disease once symptoms appear can be very rapid. A patient's condition can seriously deteriorate in as little as five days (perhaps sooner) following initial detection of symptoms. The current estimated rate for life-threatening complications is approximately 20%, with a fatality rate estimated at between 1% and 5%. All of these risk assessment numbers, however, appear to be rising.
10. It is clear that, currently, the numbers of people diagnosed reflect only a portion of those likely infected; very few people have been tested, and many are asymptomatic, so they do not even know they should be tested. As a result, thousands of people are likely living day to day and carrying a potentially fatal disease that is easily transmitted—and no one is aware of it.
11. The Mississippi State Department of Health confirmed the first COVID-19 case in the state on March 11, 2020.¹² Days later, on March 19, 2020, health officials confirmed the first coronavirus death in Mississippi.¹³ As of May 13, 2020, there were 10,090 of COVID-19 cases in Mississippi, and 465 people in Mississippi have died from the disease.¹⁴ Case totals in Mississippi increase exponentially across the state with every passing day.¹⁵ In the passing weeks and months, multiple nations have declared strict lockdowns, and American cities and institutions are closing public events, workplaces, and schools to limit the risk of person-to-person transmission and slow the spread of COVID-19.
12. On March 13, 2020, President Donald Trump announced a national state of emergency in response to the coronavirus outbreak.¹⁶ One day later, Mississippi Governor Tate Reeves issued a proclamation declaring a disaster in the State of Mississippi.¹⁷ On March 26, 2020, the Mississippi State Department of Public Health announced new and expanded means of testing and data analysis to classify the highest-risk regions and provide location-specific restrictions on movement and social interactions.¹⁸
13. On March 11, 2020, the World Health Organization declared a global pandemic based on COVID-19. Citing “deep[] concern[] both by the alarming levels spread and severity, and

¹² Tom Williams, *Coronavirus Confirmed in Mississippi*, WTOK E-News (Mar. 11, 2020), <https://www.wtok.com/content/news/Coronavirus-confirmed-in-Mississippi-568722301.html>.

¹³ Mississippi State Dept. of Health, *Health Officials Confirm First Coronavirus Death in Mississippi* (Mar. 19, 2020), <http://webpubcontent.raycommedia.com/wlox/order1-converted.pdf>.

¹⁴ Coronavirus Disease 2019 (COVID-19): Covid-19 in Mississippi and the U.S., Mississippi State Dept. of Health, https://msdh.ms.gov/msdhsite/_static/14,0,420.html (last visited May 13, 2020).

¹⁵ *Id.*

¹⁶ President Donald Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

¹⁷ Mississippi Office of the Governor, *Proclamation* (Mar. 14, 2020), available at https://www.sos.ms.gov/Content/documents/about_us/WhatsNew/GovernorProclamationPublicHealth.pdf.

¹⁸ Exec. Order No. 1466, Gov. Tate Reeves (Miss. 2020), <http://webpubcontent.raycommedia.com/wlox/order1-converted.pdf>.

by the alarming levels of inaction,” it called for countries to take “urgent and aggressive action.”¹⁹

14. There have been multiple reports of superspreading events (SSEs) of COVID-19, which are associated with both explosive growth early in an outbreak and sustained transmission in later stages.²⁰ In the US, prisons, meatpacking plants and nursing homes have been the sites of multiple SSEs due to “warehousing efforts,” where individuals are confined in close contact without adequate and proper preventive public health measures.²¹ Importantly, these SSEs often create outbreaks in the communities in which prisons, meatpacking plants and nursing homes are located.²²
15. In light of COVID-19, individuals in prisons and jails are at risk of serious harm. Prisons are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. These facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Prisons have even greater risk of infectious spread than other enclosed environments because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. During the H1N1 influenza (“Swine Flu”) epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection.²³
16. People incarcerated in prisons live in close quarters and cannot achieve the “social distancing” needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between uses. Food preparation and food service is communal, with little opportunity for surface disinfection. Spaces are poorly ventilated, which promotes highly efficient spread of diseases through droplets.
17. Many prisons lack the supplies and staff needed to perform cleaning procedures such as regular disinfection of high-touch surfaces, which is essential to preventing virus spread. Facilities often do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped

¹⁹ World Health Organization, *WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19* (Mar. 11, 2020), <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

²⁰ Thomas R. Frieden and Christopher T. Lee, *Identifying and Interrupting Superspreading Events—Implications for Control of Severe Acute Respiratory Syndrome Coronavirus 2*, Centers for Disease Control and Prevention (June 2020), https://wwwnc.cdc.gov/eid/article/26/6/20-0495_article.

²¹ Dylan Matthews, *America’s Covid-19 Hot Spots Shed a Light on our Moral Failures*, Vox (May 1, 2020), <https://www.vox.com/future-perfect/2020/5/1/21239396/covid-19-meatpacking-prison-jail-moral>; German Lopez, *Why US Jails and Prisons Became Coronavirus Epicenters*, Vox (April 22, 2020), <https://www.vox.com/2020/4/22/21228146/coronavirus-pandemic-jails-prisons-epicenters>.

²² Julie Bosman, Mitch Smith, & Amy Harmon, *With New Hot Spots Emerging, No Sign of a Respite* (May 5, 2020), <https://www.nytimes.com/2020/05/05/us/coronavirus-deaths-cases-united-states.html>.

²³ David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), <https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/>.

with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings.

18. Many prisons lack the medical care infrastructure necessary to treat infected individuals and prevent the exponential spread of infection. For example, many prisons use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Prisons are also ill-equipped to provide sufficient personal protective equipment, such as gloves, masks, gowns, and eye-shields, for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.
19. The medical facilities at jails and prisons are almost never sufficiently equipped to handle widespread outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. As an outbreak spreads, medical personnel become sick and do not show up to work. Facilities can become dangerously understaffed with healthcare providers.
20. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
21. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions may not be able to receive the care they need. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.
22. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, can result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.
23. As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.
24. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities

in Maine, resulting in two inmate deaths.²⁴ Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the swine flu outbreak in 2009, jails and prisons experienced a disproportionately high number of cases.²⁵ Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

25. Due to the crowded conditions and scarcity of sanitary and medical resources, transmission of infectious diseases in jails and prisons, is incredibly common. These risks are magnified for those diseases, like COVID-19, that are transmitted by respiratory droplets. An outbreak of COVID-19 in detention facilities would be devastating.
26. The experiences of other nations fighting COVID-19 outbreaks demonstrate the particular risk of COVID-19 transmission present in prison and jail settings. Prisons in China reported more than 500 cases of COVID-19 spread across four facilities, and these cases affected both correctional officers and incarcerated people.²⁶ Secretary of State Mike Pompeo has called for Iran to release U.S. citizens detained there because of “deeply troubling” “[r]eports that COVID-19 has spread to Iranian prisons,” noting that “[t]heir detention amid increasingly deteriorating conditions defies basic human decency.”²⁷
27. COVID-19 threatens the well-being of incarcerated individuals, the corrections staff who shuttle between prisons and outside communities, and members of those outside communities. Staff, visitors, contractors, and vendors who pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Strains on the medical systems of prison and jail facilities have implications for the outside hospitals and emergency departments on which those facilities already depend for intensive medical care services. Prison health is public health.

²⁴ *Influenza Outbreaks at Two Correctional Facilities – Maine*, March 2011, Centers for Disease Control and Prevention (Apr. 6 2012), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

²⁵ David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), <https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/>.

²⁶ Evelyn Cheng & Huileng Tan, *China Says More than 500 Cases of the New Coronavirus Stemmed from Prisons*, CNBC (Feb. 20, 2020), <https://www.cnbc.com/2020/02/21/coronavirus-china-says-two-prisons-reported-nearly-250-cases.html>.

²⁷ Michael R. Pompeo, *United States Calls for Humanitarian Release of All Wrongfully Detained Americans in Iran*, U.S. Dep’t of State (Mar. 10, 2020), <https://www.state.gov/united-states-calls-for-humanitarian-release-of-all-wrongfully-detained-americans-in-iran/>.

28. COVID-19 has already entered the prison and jail systems in several states and localities and has spread significantly.
29. The coronavirus has spread rapidly in various prison environments. By May 6, 2020, at least 20,119 inmates in state and federal prisons had tested positive for the illness, a 39 percent increase from the week before.²⁸ In the federal system alone, 4,224 inmates and 548 staff members have received positive test results as of May 13, 2020; and of those, 51 inmates have died of COVID-19 symptoms.²⁹
30. In the Yazoo City Federal Correctional Complex, 120 inmates and 25 staff members are reported to have tested positive for COVID-19 as of May 13, 2020; and one inmate has died.³⁰
31. The experience of other states shows that once COVID-19 begins spreading within a prison, it is only a matter of time until the outbreak spreads rapidly and hundreds are infected.
32. For example, in the Federal Correctional Complex in Oakdale, Louisiana, the first inmate, Patrick Jones, tested positive March 21 and died on March 28; since then, seven more inmates have died of COVID-19, 20 additional inmates have been hospitalized, and an additional 119 inmates and 26 staff members have tested positive.³¹
33. At the Terminal Island Federal Correctional Institution in San Pedro, California, the number of confirmed cases climbed to 620 on May 5, 2020, up from the 33 cases reported in mid-April.³² The number of infected inmates now constitutes nearly 60 percent of San Pedro's penitentiary population.³³

²⁸ A State-by-State Look at Coronavirus in Prisons, The Marshall Project (May 1, 2020), *available at* <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons#>.

²⁹ COVID-19 Coronavirus: COVID-19 Cases, Federal Bureau of Prisons, *available at* <https://www.bop.gov/coronavirus/#> (last accessed May 5, 2020).

³⁰ *Id.*

³¹ Janet Reitman, 'Something Is Going to Explode': When Coronavirus Strikes a Prison, N.Y. TIMES (Apr. 18, 2020), <https://www.nytimes.com/2020/04/18/magazine/oakdale-federal-prison-coronavirus.html?auth=login-email&login=email>.

³² COVID-19 Coronavirus: COVID-19 Cases, Federal Bureau of Prisons, *available at* <https://www.bop.gov/coronavirus/#> (last accessed May 5, 2020); More than 400 Terminal Island prison inmates test positive for COVID-19, Long Beach Post (Apr. 29, 2020), *available at* <https://lbpost.com/news/terminal-island-prison-coronavirus-half-400>.

³³ Richard Winton, Coronavirus outbreak at Terminal Island prison worsens: 5 deaths and 600 infected, L.A. Times (Apr. 30, 2020), *available at* <https://www.latimes.com/california/story/2020-04-30/la-coronavirus-outbreak-terminal-island-prison-worsens>.

34. At the Federal Medical Prison in Fort Worth, Texas, the number of confirmed cases jumped from 35 to 132 between April 21, and April 23, 2020;³⁴ the number has since increased to 647 in just over three weeks.³⁵
35. In North Carolina, at the Neuse Correctional Institution, the number of confirmed cases of COVID-19 went from 2 to 378 in just two weeks, meaning *more than half* of its inmate population is now confirmed to have the virus.³⁶
36. And at the Butner federal prison in North Carolina, it took only five days for the number of confirmed COVID-19 cases to surge from single digits to nearly 60.³⁷
37. At Trousdale Turner Correctional Center in Hartsville, Tennessee, the number of confirmed cases jumped from single digits to 1,299 inmates and 50 staff members in less than one week.³⁸ Over half of the prison's population is infected and one inmate has died of COVID-19 symptoms.³⁹
38. The jail on Rikers Island in New York City went from a single confirmed case to 287 cases in just over two weeks.⁴⁰
39. In Cook County, Illinois, the number of positive cases in the county jail rose from 2 to 291 in just two weeks.⁴¹
40. At one point, an outbreak at Marion Correctional Institution in Ohio was the largest-known source of coronavirus infections in the United States.⁴² Over 80% of the individuals incarcerated at Marion CI tested positive—in other words, over 2,000 of the

³⁴ Scott Gordon, COVID-19 Cases Nearly Quadruple Inside Fort Worth Medical Prison, NBC 5, *available at* <https://www.nbcdfw.com/news/coronavirus/covid-19-cases-quadruple-to-132-at-fort-worth-federal-prison/2356912/>.

³⁵ COVID-19 Coronavirus: COVID-19 Cases, Fed. Bureau of Prisons ("BOP"), *available at* <https://www.bop.gov/coronavirus/#> (last accessed May 6, 2020).

³⁶ 280+ Test Positive for COVID-19 At NC Prison Near Goldsboro, WWAY News (Apr. 18, 2020), <https://www.wwaytv3.com/2020/04/18/280-test-positive-for-covid-19-at-nc-prison-near-goldsboro/>.

³⁷ COVID-19 cases at federal prison in Butner jump from 9 to 59 in five days, CBS 17 (Apr. 6, 2020), *available at* <https://www.cbs17.com/news/local-news/covid-19-cases-at-federal-prison-in-butner-jump-from-9-to-59-in-five-days/>.

³⁸ TDOC Inmates VODI-19 Testing, Tennessee Department of Corrections, *available at* <https://www.tn.gov/content/dam/tn/correction/documents/TDOCInmatesCOVID19.pdf> (last accessed May 7, 2020); CoreCivic Releases COVID-19 Testing Results for Trousdale Turner Correctional Center, CoreCivic, *available at* <https://www.corecivic.com/corecivic-releases-covid-19-testing-results-for-trousdale-turner-correctional-center> (last accessed May 7, 2020).

³⁹ *Id.*

⁴⁰ COVID-19 Infection Tracking in NYC Jails, The Legal Aid Society, *available at* <https://legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/> (last visited Apr. 27, 2020).

⁴¹ Tyler Kendall, "We're at war with no weapons": Coronavirus cases surge inside Chicago's Cook County jail, CBS NEWS (Apr. 5, 2020), *available at* <https://www.cbsnews.com/news/chicago-cook-county-jail-coronavirus-life-inside-covid-19-cases/>.

⁴² Rick Rojas and Michael Cooper, Georgia, Tennessee and South Carolina Say Businesses Can Reopen Soon, N.Y. TIMES (Apr. 20, 2020), *available at* <https://www.nytimes.com/2020/04/20/us/coronavirus-us-hot-spots-reopening.html>.

2,500 inmates.⁴³ That county is now experiencing above average rates of community spread outside the prison.⁴⁴

41. In Arkansas, an outbreak at the Department of Corrections' Cummins Unit spread rapidly. The outbreak is believed to have started after a single staff member tested positive in late March. By April 12, the facility's first inmate tested positive. Within a few days, it was confirmed that 44 out of the 46 other inmates housed in that inmate's barracks were also infected. By April 20, the facility had over 600 confirmed infections, which accounted for nearly one-third of all cases in the entire state.⁴⁵
42. The only viable public health strategy available is risk mitigation. In my opinion, from an epidemiological perspective, prisons, jails, and detention centers should immediately take the steps necessary to provide for the release of any incarcerated persons who can safely be released. Such steps are necessary for the safety of incarcerated individuals as well as the broader community as we address the rapid global outbreak of COVID-19.
43. Releasing incarcerated persons has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of prison or detention staff such that they can continue to ensure the safety of inmates or detainees. The United Nations High Commissioner for Refugees, recognizing the serious public health risks posed by prisons and detention centers, has urged governments to release prisoners and detainees in order to protect their safety and as part of larger efforts to quell the spread of the virus.⁴⁶ Releasing inmates older inmates, inmates with underlying medical conditions, and inmates with disabilities and who are at increased risk of contracting, becoming severely ill from, and/or dying from COVID-19 due to their disability or any medical treatment necessary to treat their disability is even more critical. Such individuals are by definition at greater risk if they remain incarcerated under conditions necessarily present in any detention setting.
44. For those inmates not released, it is critical to take measures that, while markedly insufficient in comparison to release, have at least some chance of slowing down the otherwise rapid spread of COVID-19 within the prison setting. The CDC guidelines present the barest minimum with respect to such measures, which must necessarily include at least:

⁴³ Sarah Volpenhein, *Marion prison coronavirus outbreak seeping into larger community*, MARION STAR (Apr. 25, 2020), <https://www.marionstar.com/story/news/local/2020/04/25/marion-prison-ohio-coronavirus-outbreak-seeping-into-larger-community/3026133001/>.

⁴⁴ *Id.*

⁴⁵ Meghan Roos, *One Arkansas Prison Make Up Almost a Third of State's Coronavirus Cases*, NEWSWEEK (Apr. 20, 2020), available at <https://www.newsweek.com/one-arkansas-prison-makes-almost-third-states-coronavirus-cases-1499045>.

⁴⁶ Michelle Bachelet, UN High Commissioner for Refugees, Urgent Action Needed to Prevent COVID-19 "Rampaging Through Places of Detention" (Mar. 25, 2020), <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25745&LangID=E>.

- a. *Intensified cleaning and disinfecting procedures, even in those facilities where COVID-19 cases have not yet been identified.* Frequently touched surfaces and objects should be cleaned and disinfected several times per day, especially in common areas, with EPA-registered disinfectants effective against the coronavirus.⁴⁷ “Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).”⁴⁸ In addition to regular cleaning routines, prison staff should also “thoroughly clean and disinfect all areas where [a] confirmed or suspected COVID-19 case spent time.”⁴⁹
- b. *Provision of adequate cleaning supplies and personnel.* Facilities should ensure adequate supplies to support intensified cleaning and disinfection practices.⁵⁰ The CDC also strongly recommends “increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of [common] areas throughout the day.”⁵¹
- c. *Provision of a no-cost supply of soap and other hand washing materials to incarcerated persons, sufficient to allow frequent hand washing.* Liquid soap should be provided where possible, and if bar soap must be used, prison authorities should “ensure that it does not irritate the skin and thereby discourage frequent hand washing.”⁵² Facilities should also provide inmates with running water and hand drying machines or disposable paper towels for hand washing; tissues and no-touch trash receptacles for disposal; and alcohol-based sanitizer with “at least 60% alcohol where permissible based on security restrictions.”⁵³ The CDC recommends allowing staff to carry individual-sized bottles of sanitizer to maintain hand hygiene.⁵⁴
- d. *Social distancing.* Prison facilities should implement “social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).”⁵⁵ The CDC’s prescribed measures for implementation of social distancing include enforcing increased spacing between individuals in holding cells and other common spaces, such as dining halls, recreational areas, intake and waiting areas, and medical examination rooms.⁵⁶ In housing units, prison administrators should “reassign bunks [to the extent possible] to provide more space between

⁴⁷ CDC Guidance at 9.

⁴⁸ *Id.*

⁴⁹ *Id.* at 17.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* at 10.

⁵⁴ *Id.*

⁵⁵ *Id.* at 11.

⁵⁶ *Id.*

individuals” and “arrange bunks so that individuals sleep head to foot to increase the distance between them.”⁵⁷

- e. *Provision of up-to-date information about COVID-19.* Prison authorities should “communicate clearly and frequently with incarcerated/detained persons about changes to their daily schedule and how they can contribute to [COVID-19] risk reduction.”⁵⁸ They should [p]rovide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis.”⁵⁹ Authorities should post signage throughout the prison facility that (1) identifies the symptoms of COVID-19, (2) provides hand hygiene instructions, and (3) instructs incarcerated people to report symptoms to staff; they should also ensure that “signage is understandable for non-English speaking persons and those with low literacy[.]”⁶⁰ Finally, authorities should “communicate [COVID-19] information verbally on a regular basis[.]”⁶¹ and “consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.”⁶²
- f. *A reliable means by which incarcerated people report symptoms of coronavirus and be seen the same day by medical staff, even if no guards or few guards are on duty in their housing units.* “As soon as an individual develops symptoms of COVID-19, they should wear a face mask . . . and should be *immediately* placed under medical isolation[.]”⁶³ Immediate action decreases the possibility that a person with the virus will transmit it to others in the unit. For immediate action to occur, a means must exist for residents to inform staff who will take prompt action.
- g. *Temperature checks.* Prison authorities should implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.⁶⁴

45. It is my expert opinion that in addition the CDC guidelines, Prison Authorities should also implement the following precautions and procedures in effort to effectively slow the rapid spread of COVID-19 in prisons:

- a. *Cleaning frequently touched surfaces and objects on shared equipment.* Prison Authorities should ensure that places and objects, like yard equipment, furniture, holding tanks, and transport vans, are cleaned and disinfected several times per day with EPA-registered disinfectants effective against the coronavirus.

⁵⁷ *Id.*

⁵⁸ *Id.* at 12.

⁵⁹ *Id.*

⁶⁰ *Id.* at 6.

⁶¹ *Id.* at 10.

⁶² *Id.* at 12.

⁶³ *Id.* at 15 (emphasis added).

⁶⁴ CDC Guidance at 12.

- b. *Advertisement of medical fee waiver.* CDC guidance recommends that Prison Authorities “consider suspending co-pays for incarcerated/detained persons asking for medical evaluation for respiratory symptoms.”⁶⁵ However, this suspension has little effect if inmates are not aware of it. Prison Authorities must clearly and repeatedly inform residents of the fee waiver so that the benefit of doing so—encouraging swift identification and isolation of positive cases—is realized. This should include verbal reminders and signage in multiple languages.
- c. *Soap replenishment.* In addition the cost-free provision of soap recommended by the CDC, prisons should implement a facility-wide protocol, and effectively train residents and staff to use it, whereby a resident who runs out of soap can obtain more promptly.
- d. *Reporting of violations.* Effective written policies mean nothing if they are not enforced. Facilities should provide an anonymous mechanism for incarcerated individuals to report ineffective implementation of policies, including if staff violate protocol, so that appropriate corrective action may be taken.
- e. *Medical isolation unique from solitary confinement.* Solitary confinement and quarantine do not provide the protections of medical isolation and should not be used as an alternative.⁶⁶ Moreover, use of solitary confinement can greatly exacerbate mental health conditions, further putting inmates at risk.⁶⁷

46. I have personally reviewed the declarations of Tony Smith, Roger Ewing, Daniel Hatten, Brittany Waddell (all incarcerated in CMFC); Jamarus Davis, Bob Henderson, Thomas Holder, Erik Lewis, Douglass Triplett (all incarcerated in SMCI); and Oziel Guzman, on behalf of his father Juan Guzman (incarcerated in SMCI). Based on my review of these inmate declarations, I conclude that the Mississippi Department of Corrections is (1) failing to release individuals with disabilities who require release under present circumstances, (2) failing to take the measures articulated in paragraphs 44(a)—(g) above for the protection of inmates not released,⁶⁸ (3) failing to take the additional measures

⁶⁵ *Id.* at 9.

⁶⁶ Prison facilities should follow the recommendations of David Cloud, JD, MPH, Dallas Augustine, MA, Cyrus Ahalt, MPP, and Brie Williams, MD, MS articulated in their paper, *The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings*. See David Cloud, JD, MPH, Dallas Augustine, MA, Cyrus Ahalt, MPP, & Brie Williams, MD, M, *The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings*, Amend (April 9, 2020), https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.

⁶⁷ K. Reiter, J. Ventura, D. Lovell, D. Augustine, M. Barragan, T. Blair, K. P. Dashtgard, G. Gonzalez, N. Pifer, & J. Strong, *Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2018-2018*, Am. Pub. Health Ass. (Jan. 22, 2020), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2019.305375>.

⁶⁸ Common areas are rarely cleaned due to lack of chemicals and supervision. See Smith Decl. ¶¶ 28, 31 (inmates have no chemicals to sanitize their personal space); Ewing Decl. ¶¶ 13, 16 (staff does not enforce daily clean or provide supplies). Residents are not provided with updated information regarding coronavirus or protective

articulated in paragraphs 45(a)-(e) above for the protection of inmates not released,⁶⁹ and (4) failing to take measures sufficient to have any reasonable hope of appreciably slowing the spread of COVID-19 within the prison setting. I have been made aware that Roger Ewing, Bob Henderson, Thomas Holder, Erick Lewis, and Douglass Triplett are included within a proposed Disability Subclass in the above-captioned litigation. I have personally reviewed the declarations of each of these inmates. Based on the representations of these inmates in their declarations, and operating under the premise that such representations are accurate, I conclude that each of these individuals suffer from a disability that substantially limits one or more of their major life activities and are at increased risk of contracting, becoming severely ill from, and/or dying from COVID-19 due to their disability or any medical treatment necessary to treat their disability.

47. The public health crisis requires each and every one of us to re-evaluate how we conduct our lives and care for one another. Institutions responsible for the care and custody of vulnerable populations must take unique steps to “flatten the curve” and slow the spread of this virus. Incarcerating as few individuals as possible will help mitigate the harm from a COVID-19 outbreak.
48. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court.

measures. *See* Waddell Decl. ¶ 3. Inmates are unable to wash hands due to lack of soap and skin irritation. *See* Davis Decl. ¶ 23 (inmates will avoid washing hands to preserve soap for showers); Triplett Decl. ¶ (describing avoiding using soap to wash hands because the state soap irritates his skin). Inmates are not permitted to wear the masks they are given, and neither guards nor medical staff wear masks regularly or properly. *See* Smith Decl. ¶ 44 (inmates received masks at the end of April but were instructed not to wear them); Hatten Decl. ¶ 15 (less than half of guards wear masks, and residents generally do not); Lewis Decl. ¶¶ 11-12, 42 (same). It is impossible to maintain social distancing. *See* Ewing Decl. ¶ 26; Davis Decl. ¶ 27. Areas where confirmed or suspected COVID-19 positive people have spent time are not thoroughly cleaned and disinfected. *See* Waddell Decl. ¶ 4. Facilities are dangerously understaffed, meaning medical emergencies are left unresponded to. *See* Ewing Decl. ¶¶ 3-5, 6; Waddell Decl. ¶ 22; Henderson Decl. ¶ 4; Lewist Decl. ¶¶ 15, 47 (residents have died because officers did not attend to medical emergencies); Triplett Decl. ¶ 11 (same). Daily temperature checks have not been implements in housing units where COVID-19 cases have been identified. *See* Waddell Decl. ¶ 5 (“During the fourteen-day quarantine period, we had our temperature check a total of three times.”).

⁶⁹ Residents attend yard together regardless of zone quarantines, and residents share equipment. Waddell Decl. ¶ 8. The equipment is not sanitized, despite being used by residents from zones with suspected coronavirus cases. *Id.* Soap is not readily available. *See* Davis Decl. ¶ 23 (resident request for more soap was refused). ARP forms are frequently left unanswered, and official responses are often delayed. *See* Smith Decl. ¶¶ 49-51; Waddell Decl. ¶ 42; Davis Decl. ¶ 33. Guards and officials offer thinly veiled threats of retaliation against residents who wish to submit ARP. *See* Triplett ¶¶ 27, 33 (describing fear of retaliation and officials’ threats specifically related to coronavirus ARPs); Waddell Decl. ¶ 42 (describing retaliation for filing grievances). Residents are not aware that MDOC has waived the \$6 medical fee for respiratory symptoms, and many noted that the fee is a deterrent for reporting illnesses or requesting medical attention. *See* Smith Decl. ¶ 5; Ewing Decl. ¶ 28; Hatten Decl. ¶ 18; Waddell Decl. ¶ 40; Davis Decl. ¶ 28; Henderson Decl. ¶ 37; Holder Decl. ¶ 21.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.

Executed this 14th day in May 2020 in New Haven, CT.

A handwritten signature in cursive script that reads "Gregg Gonsalves".

Gregg Gonsalves
Assistant Professor of Epidemiology (Microbial Diseases)
Yale School of Public Health
350 George Street
New Haven, CT 06511
gregg.gonsalves@yale.edu

APPENDIX 1

Gregg S. Gonsalves, Ph.D.

Date of Revision: 4 May 2020**Name:** Gregg S. Gonsalves, Ph.D.**Appointment:** Assistant Professor with Term in the Department of Epidemiology of Microbial Diseases, Traditional Track**Term:** Primary Appointment: July 1, 2020 to June 30, 2023**School:** Yale University School of Medicine and the Graduate School**Education:**

B.S. (with distinction) Yale College (Biology) 2011

M.Phil. Yale School of Public Health 2015

Ph.D. Yale School of Public Health 2017

Career/Academic Appointments:

2018- Affiliated Faculty, Yale Program in Addiction Medicine, Yale School of Medicine, New Haven, CT

2017- Affiliated Faculty, Public Health Modeling Concentration, Yale School of Public Health New Haven, CT

2017- Assistant Professor, Department of the Epidemiology of Microbial Diseases, Yale School of Public Health, New Haven, CT

2017- Associate Professor (Adjunct) of Law, Yale Law School, New Haven, CT

2017- Affiliated Faculty, Women's, Gender, & Sexuality Studies, Yale University, New Haven, CT

2017- Affiliated Faculty, Jackson Institute for Global Affairs, Yale University, New Haven, CT

2012- Research Scholar in Law, Yale Law School, New Haven, CT

2012-2017 Lecturer in Law, Yale Law School, New Haven, CT

2011-2012 Post-Graduate Research Fellow, Department of the Epidemiology of Microbial Diseases, Yale School of Public Health, New Haven, CT

2011-2012 Research Scholar, University of Cape Town, Centre for Social Science Research, Cape Town, South Africa

2011-2012 Fellow, Harvard Medical School, Department of Global Health and Social Medicine, Boston, MA

2010 Summer Research Associate, l'unité Régulation des infections rétrovirales, Institut Pasteur, Paris, France

Administrative Positions:

2017- Co-Faculty Director, Global Health Studies, Yale College, New Haven, CT

2016- Co-Director, Collaboration for Research Integrity and Transparency, Yale Law School Yale School of Public Health and Yale Medical School, New Haven, CT

2012- Co-Director, Global Health Justice Partnership, Yale Law School and Yale School of Public Health, New Haven, CT

2006-2008 Coordinator, AIDS and Rights Alliance for Southern Africa, Cape Town, South Africa

Gregg S. Gonsalves, Ph.D.

2000-2006 Director of Treatment and Prevention Advocacy, Public Policy Department, Gay Men's Health Crisis, New York, NY

1991-2000 Co-Founder and Policy Director, Treatment Action Group, New York, NY

Professional Honors & Recognition:**International/National/Regional**

2018: MacArthur Fellow, MacArthur Foundation

2014: Albert and Mary Lasker Foundation Essay Contest

2011: William R. Belknap Prize for Excellence in Biology (the highest honor bestowed on undergraduates in the department and awarded to one student each year), Yale College

2011: Open Society Foundations Fellowship

2010: Alan S. Tetelman 1958 Fellowship for International Research in the Sciences, Yale College

2008: John M. Lloyd Foundation Leadership Award

2001: Treatment Action Group Research in Action Award

Grant History:**Current Grants**

Agency: MacArthur Foundation

I.D.# N/A

Title: MacArthur Fellowship

P.I.: Gregg S. Gonsalves

Percent effort: N/A (unrestricted award for personal use)

Direct costs for project period: \$625,000

Project period: 1/1/2019-12/31/2023

Agency: National Institute on Drug Abuse

I.D.# DP2DA49282-01

Title: *Avenir Award Program for Research on Substance Abuse and HIV/AIDS*
 “Novel Adaptive Approaches to Predicting and Responding to Outbreaks of Overdose, HIV and HCV Among People Who Use Drugs”

P.I.: Gregg S. Gonsalves

Percent effort: 25% (*DP2 awards have no pre-specified budget, but require at least 25% effort*)

Direct costs for project period: \$1,500,000

Total costs for project period: \$2,512,500

Project period: 07/01/2019-05/31/2024

Agency: National Institute on Drug Abuse

I.D.# R37DA15612-16

Title: “Making Better Decisions: Policy Modeling for AIDS & Drug Abuse”

P.I.: Douglas Owens, Stanford; Yale Subaward PI: David Paltiel

Percent effort: 25%

Direct costs per year: \$60,141 (Yale Subaward Only; Current Year Direct)

Gregg S. Gonsalves, Ph.D.

Total costs for project period: \$3,942,000
 Project period: 09/25/2002 – 01/31/2023

Agency: National Institute of Allergy and Infectious Diseases
 I.D.# 5R01AI042006-22
 Title: “Cost-Effectiveness of Preventing HIV Complications” (CEPAC-US)
 P.I.: Kenneth Freedberg, Massachusetts General Hospital; Yale Subaward PI: David Paltiel

Percent effort: 20%
 Direct costs per year: \$28,198 (Yale Subaward Only; Current Year Direct)
 Project Period: 04/01/1998 – 07/31/2020

Past Grants

Agency: National Institute of Mental Health
 I.D.# 5R01MH105203-04
 Title: “Novel Approaches to the Design and Evaluation of Combination HIV Prevention”
 P.I.: David Paltiel

Percent effort: 5%
 Direct costs per year: \$564,682
 Total costs for project period: \$3,309,826
 Project period: 06/25/2014 – 02/28/2020

Agency: Laura and John Arnold Foundation
 I.D.# Research Integrity Initiative Grant
 Title: “Yale Collaboration for Research Integrity and Transparency”
 P.I.: Gregg S. Gonsalves (co-P.I. with Amy Kapczynski, J.D. and Joseph Ross, M.D.)

Percent effort: 5%
 Direct costs per year: \$841,619
 Total costs for project period: \$3,023,059
 Project period: 07/01/2016 – 07/1/2019

Agency: Levi-Strauss Foundation
 I.D. # R13002
 Title: “Yale Global Health Justice Partnership Summer Fellowship Program”
 P.I.: Alice Miller, JD

Percent effort: 1.54%
 Direct costs per year: \$50,000
 Total costs for project period: \$100,000
 Project Period: 05/1/2015-4/30/2017

Agency: Public Health Services and Systems Research (PHSSR)/University of Kentucky Research Foundation
 I.D.# Fellowship
 Title: “PHSSR Pre-doctoral Scholar in Public Health Delivery”
 P.I.: Gregg S. Gonsalves

Percent effort: 100%

Gregg S. Gonsalves, Ph.D.

Total costs for project period: \$24,472
 Project period: 10/1/2014 – 9/1/2015

Agency: Open Society Foundations
 I.D.# Fellowship
 Title: “Open Society Fellowship”
 P.I.: Gregg S. Gonsalves
 Percent effort: 100%
 Total costs for project period: \$150,000
 Project period: 07/1/2011 – 07/1/2012

Agency: John M. Lloyd Foundation
 I.D.# Fellowship
 Title: “AIDS Leadership Award”
 P.I.: Gregg S. Gonsalves
 Percent effort: 100%
 Total costs for project period: \$100,000
 Project period: 09/1/2008 – 09/1/2009

Other Grant History (*aggregate figures for programs that I managed and grant funding when working for non-governmental organizations outside of academia*):

Agency: The Joint United Nations Programme on AIDS; Public Welfare Foundation; John M. Lloyd Foundation; Swedish International Development Agency; UK Department for International Development; Royal Dutch Netherlands Embassy; IrishAID; HIVOS Foundation; Stephen Lewis Foundation
 I.D. # Program Budget
 Title: “AIDS and Rights Alliance for Southern Africa Treatment Literacy and Advocacy Program”
 P.I.: Gregg S. Gonsalves
 Percent effort: 100%
 Total costs for project period: \$1,150,000
 Project period: 06/1/2006 – 06/1/2008

Agency: Bill and Melinda Gates Foundation; Doris Duke Charitable Trust; Sainsbury Family Trusts/Monument Trust
 I.D. # Program Budget
 Title: “The CD4 Initiative at Imperial College (UK)”
 P.I. Gregg S. Gonsalves (founder/board chair) Hans-Georg Batz, Ph.D. (project director)
 Percent effort: 25%
 Total costs for project period: \$9,000,000
 Project period: 06/1/2005 – 03/1/2010

Agency: John M. Lloyd Foundation; Overbrook Foundation; New York Community Trust; Rockefeller Foundation; Bill and Melinda Gates Foundation; Open Society Foundations; Bristol-Myers Squibb; Boehringer-Ingelheim; Merck; Broadway Cares--Equity Fights AIDS; National Institutes of Health; American Foundation for AIDS Research; Doris Duke Charitable Foundation
 I.D. # Program Budget
 Title: “Gay Men’s Health Crisis Treatment and Prevention Advocacy Program”

Gregg S. Gonsalves, Ph.D.

P.I. Gregg S. Gonsalves
 Percent effort: 100%
 Total costs for project period: \$1,150,000
 Project Period: 6/1/2000-6/1/2006

Agency: John M. Lloyd Foundation; Overbrook Foundation; New York Community Trust; Aaron Diamond Foundation; Royal S. Marks Foundation, Michael Palm Foundation, American Foundation for AIDS Research

I.D. # Program Budget
 Title: "Treatment Action Group Program Budget"
 P.I. Gregg S. Gonsalves (co P.I. with Mark Harrington)
 Percent effort: 100%
 Total costs for project period: \$3,120,000
 Project Period: 1/1/1993-6/1/2000

Invited Speaking Engagements, Presentations, Symposia & Workshops:

International/National

2020 Department of Public Health Sciences, University of Chicago, Chicago, IL, "An Adaptive Approach to Locating Mobile HIV Testing Services"

International Conference on Health Policy Statistics, San Diego, CA, "Using Risk Maps to Pre-Deploy Services for Overdose, HIV and Hepatitis C Among People Who Inject Drugs"

New York University Langone Medical Center, New York, NY, "Non-Trial Preapproval Access to Investigational Medical Products: Lessons Learned and Practical Advice Moving Forward"

2019 New England AIDS Education and Training Center, Boston, MA, "Applying 35 Years of HIV Work to the Substance Use Epidemic"

HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University, New York, NY, "Causal Inference and Structural Interventions for HIV Prevention" as part of symposium on "Staying at Zero: The Role of Social Science in Ending the HIV Epidemic"

Northeastern University School of Law, Boston, MA, "Annual Lecture in Health Policy and Law"

Kaiser Permanente School of Medicine, Pasadena, CA, "We Will Be Citizens: From AIDS Activism to Mobilizing for Global Health Justice"

Providence/Boston Center for AIDS Research Annual Research Forum, Brown University, Providence RI, "Closing Plenary: We Will Be Citizens: From AIDS Activism to Mobilizing for Global Health Justice"

Decolonizing Global Health Conference, Harvard School of Public Health, Boston, MA, "Closing Plenary - Solidarity-oriented approaches: subverting the status quo of global health"

Gregg S. Gonsalves, Ph.D.

Special Lecture Series on Global Public Health, “We Will Be Citizens: From AIDS Activism to Mobilizing for Global Health Justice,” University of South Alabama, Mobile, AL

2018 Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, Panel Presentation and Discussion, “30th Anniversary of Seize Control of the FDA: Protest, Crisis, and Public Health”

2016 Department of Health Policy, Management, and Behavior, University at Albany, School of Public Health, Albany, NY, “Sanitation and Sexual Violence in an Urban Township in Cape Town, South Africa: A Modeling Study”

Academy Health Annual Research Meeting, Boston, MA, Panel Presentation and Discussion, “Entrepreneurship in Bridging Evidence, Policy and Practice: A Conversation”

European Public Health Alliance, Brussels, Belgium, The push towards accelerated market approvals: What does it mean for drug development, patient safety and access to medicines in Europe?, Panel Presentation and Discussion, “Our agenda - What kind of market access system do we want in Europe?”

Northeastern University School of Law, Boston, MA, Individual Choice v. Collective Destiny: the Future of Public Health, Panel Presentation and Discussion, “We Will Be Citizens: On Global Health Justice”

2015 Yale Law School, Gruber Program for Global Justice and Women’s Rights, “In and out of the ivory tower: How can Northern Universities Advance Global Health Justice”

Food and Drug Administration (FDA), National Institute of Allergy and Infectious Diseases (NIAID), Assistant Secretary for Preparedness and Response and the Centers for Disease Control and Prevention, Bethesda, MD, Clinical Trial Designs for Emerging Infectious Diseases, Panel Presentation and Discussion, “The Challenges of Developing New Treatments for Life-Threatening Diseases: From HIV-AIDS to EVD”

National Physicians Alliance, Washington, DC, Truth to Power: Alliance for the Public Good, Panel Presentation and Discussion, “Incentivizing Innovation: How Do We Ensure Safe, Effective Drugs and Devices?”

Keeneland Public Health Services and Systems Research Conference, Lexington, KY, Poster Presentation, “Go With the Flow: Understanding the Temporal Dynamics of the HIV Continuum of Care or the HIV Treatment Cascade”

2008 The XVII International AIDS Conference, Mexico City, Mexico, Plenary Session, “Scaling Up Antiretroviral Therapy and the Struggle for Comprehensive Primary Care”

2007 The 18th International Conference on the Reduction of Drug Related Harm, Warsaw, Poland, Plenary Session, “A Report from the Ghost of Christmas Past”

2006 The XVI International AIDS Conference, Toronto, Canada, Plenary Session, “25 years of AIDS: Looking Back, Looking Forward”

Gregg S. Gonsalves, Ph.D.

Priorities in AIDS Care and Treatment Conference, Cape Town, South Africa, Plenary Session, “Reason, Rationality and Madness and the AIDS Epidemic”

2004 The XV International AIDS Conference, Bangkok, Thailand, Panel Presentation and Discussion, “How to Lose the War on AIDS”

The XV International AIDS Conference, Bangkok, Thailand, Panel Presentation and Discussion, “The Mysteries of Community Capital”

Oral presentations on AIDS research and treatment at meetings, including the International Congress on Drug Therapy for HIV Infection; International Conference on AIDS; the Keystone Symposium on HIV Pathogenesis; The White House Conference on AIDS; National Task Force on AIDS Drug Development; European AIDS Treatment Group Eastern States Conference; Médecins Sans Frontières’ meeting on How to Simplify and Adapt ARV Combination Therapies and Monitoring for Use in Low and Middle Income Countries; WHO International Consultative Meeting on HIV/AIDS Antiretroviral Therapy; WHO Informal Consultation on Harmonization of Strategies for HIV/AIDS Diagnostic Support.

Other presentations: Harvard College, Yale College, Mt. Sinai School of Medicine, Institut Pasteur, Phillips Andover Academy, Columbia University, Stetson University, Eurasia Foundation, Open Society Foundations, Central European University.

Professional Service:

Peer Review Groups/Grant Study Sections

2000-2004 Member, American Foundation for AIDS Research, Basic Research Peer Review Committee
 2003 Member, Expert Review Panel, Doris Duke Charitable Foundation’s Innovation in Clinical Research Award on Point-of-Care Diagnostics and Therapeutic Monitoring of AIDS in Resource-Poor Countries
 1998 Member, Ad-Hoc Peer Review Panel for the Centers for AIDS Research, NIH/NIAID
 1996 Member, Ad-Hoc Peer Review Panel for the AIDS Clinical Trials Group, NIH/NIAID
 1996 Member, Ad-Hoc Peer Review Panel for the California Centers for AIDS Research, California State AIDS Research Program

Journal Service

Reviewer: *British Medical Journal*; *PLoS Medicine*; *Journal of Urban Health*; *Globalization and Health*; *Health Affairs*; *Milbank Quarterly*; *JAMA Internal Medicine*.

Advisory Bodies for Federal and International Agencies and Foundations

2019-2020 Scientific Programme Committee, Track C: Epidemiology and Prevention Research, 23rd International AIDS Conference
 2019 Member, NIH Workshop on HIV-Associated Comorbidities, Syndemics Working Group
 2017-2018 Member, Office of AIDS Research Ad Hoc Cost-Sharing Task Force, NIH

Gregg S. Gonsalves, Ph.D.

2017-2018	Member, Committee on Return of Individual-Specific Research Results Generated in Research Laboratories, National Academy of Sciences, Engineering, and Medicine
2001-2006	Member, Panel on Clinical Practices for the Treatment of HIV (convened by the Department of Health and Human Services and the Henry J. Kaiser Family Foundation)
2005-2006	Member, UNAIDS/UK Department for International Development Global Steering Committee on Universal Access to HIV Treatment, Care and Prevention
2000-2002	Member, Office of AIDS Research International Research Planning Group, NIH
1998-2002	Member, Office of AIDS Research Advisory Council, NIH
2002	Member, World Health Organization Planning Committee for Development of an International Plan of Action for Scale-Up of Antiretroviral Therapy
2001	Member, World Health Organization Antiretroviral Treatment Working Group
2000	Member, Search Committee for the Director of the Office of AIDS Research, NIH
1998	Member, Search Committee for the Director of the Office of AIDS Research, NIH
1995-1996	Member, Food and Drug Administration, Antiviral Drugs Advisory Committee
1995-1996	Member, NIH AIDS Research Program Evaluation Working Group
1995-1996	Member, NIH Etiology and Pathogenesis Area Review Panel

Meeting Planning/Participation

2017	Chair, Yale Collaboration for Research Integrity and Transparency and European Public Health Alliance, Conference on Ensuring Safety, Efficacy and Access to Medical Products in the Age of Global Deregulation
2012	Co-Chair, Yale Global Health Justice Partnership Meeting on Mining, Tuberculosis and Silicosis in Southern Africa
2008	Co-Chair, Médecins Sans Frontières, Treatment Action Group, AIDS & Rights Alliance for Southern Africa Meeting on Development of Point-of-Care Assays for the Diagnosis of Tuberculosis
2008	Co-Chair, Treatment Action Campaign and AIDS & Rights Alliance for Southern Africa Meeting on Mines, Tuberculosis and Southern Africa
2007	Co-Chair, Treatment Action Campaign and AIDS & Rights Alliance for Southern Africa Meeting on Emergency Southern African Advocacy Summit on TB and HIV
2006	Chair, GMHC Forum on Structural Factors Driving Risk of HIV Transmission Among Gay Men and Communities of Color: Drug Use, Depression, Violence, Incarceration
2006	Chair, GMHC Conference on Moving towards Universal Access: Identifying Public Policies for Scaling Up AIDS Treatment and Strengthening Health Systems in Developing Countries
2005	Chair, GHMC and Human Rights Watch Symposium on HIV Testing and Human Rights
2001	Co-Chair, GMHC/Project Inform Workshop on Diagnostic and Monitoring Tools for the Management of Antiretroviral Therapy in Resource-Poor Settings
2000	Co-Chair, Treatment Action Group American Foundation for AIDS Research Workshop on New Viral and Cellular Targets for Antiretroviral Therapy
1997-1998	Member, Scientific Planning Committee, XII International Conference on AIDS
1996	Co-Chair, Treatment Action Group American Foundation for AIDS Research Workshop on Cellular and Systemic Reservoirs for HIV in Patients on Highly Active Antiretroviral Therapy
1993	Member, Planning Committee, NIH Conference on Immunologic and Host Genetic Resistance to HIV Infection and Disease

Gregg S. Gonsalves, Ph.D.

Yale School of Public Health Service

- 2018- Co-Chair, Epidemiology of Microbial Disease Seminar Committee, Yale School of Public Health
- 2018- Member, Wilbur Downs Fellowship Committee, Yale School of Public Health
- 2017 Member, Faculty Search Committee, Social and Behavioral Sciences, Yale School of Public Health

Public Service

- 2017- Member, Board of Directors, CitySeed, New Haven, CT
- 2007- Chair, Board of Directors, International Treatment Preparedness Coalition
- 2007-2013 Member, Bill & Melinda Gates Foundation/Henry J. Kaiser Family Foundation Global HIV Prevention Working Group
- 2000-2010 Chair, The CD4 Initiative at Imperial College, UK
- 2000-2005 Member, Board of Directors, Alliance for Microbicide Development
- 1989-1992 Member, AIDS Coalition to Unleash Power

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44. **Gonsalves G.** Beating Covid-19 Will Take Coordination, Experimentation, and Leadership. *The Nation*, April 23, 2020.
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EXHIBIT 2

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION**

BRITTANY WADDELL, ROGER EWING,
TONY SMITH, DANIEL HATTEN,
DOUGLASS TRIPLETT, ERIK LEWIS, BOB
HENDERSON, THOMAS HOLDER, and
JAMARCUS DAVIS, individually and on behalf
of a class of all others similarly situated,

Plaintiffs,

v.

TOMMY TAYLOR, in his official capacity as
Interim Commissioner of the Mississippi
Department of Corrections; RON KING, in his
official capacity as Superintendent of Central
Mississippi Correctional Facility; and JOE
ERRINGTON, in his official capacity as
Superintendent of South Mississippi
Correctional Institution,

Defendants

Civil Action No. 3:20-cv-340-TSL-RHW

REPORT OF HOMER VENTERS, MD, MS

May 24, 2020

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This is a review of the Mississippi Department of Corrections' (MDOC) COVID-19 response at Central Mississippi Correctional Facility (CMCF) and South Mississippi Correctional Institute (SMCI), which together house approximately 6,000 individuals.¹ Unless otherwise noted, my reference to MDOC's actions refer to their actions at CMCF and SMCI.

I. BACKGROUND AND QUALIFICATIONS

1. I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people.² My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as testimony before the U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included

¹ May 2020 Fact Sheet, MDOC, available at <https://www.mdoc.ms.gov/Admin-Finance/MonthlyFacts/2020-5%20Fact%20Sheet.pdf>.

² My curriculum vitae is attached as Appendix 1.

oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews as well as all training and oversight of physicians, nurses, and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints.

3. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks.

4. In March 2017, I left Correctional Health Services of New York City to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers. I subsequently worked with the nonprofit Community Oriented Correctional Health Services (COCHS) in promoting evidence-based health services for people with justice involvement. I have also worked as an independent correctional health expert since 2017. In my roles as a correctional health physician I have conducted over 50 facility inspections, three of which have been specific for assessing the adequacy of COVID-19 response.

5. The following report is submitted as an evaluation of MDOC's current COVID-19 response.

6. The purpose of this report is to focus on the adequacy of infection control and other public health measures currently being implemented to prevent serious illness and death among staff and detained people, including people with medical vulnerabilities as identified by the CDC, within these facilities in light of the current COVID-19 pandemic.

7. I have been retained as an expert by counsel for the plaintiffs in the above-captioned matter. I am being compensated for my work. This remuneration is not contingent on my opinions and does not influence my conclusions in any way.

II. METHODOLOGY

8. I have conducted this assessment and review of information with the following questions in mind:

- a. Do MDOC's current practices detect the number and severity of COVID-19 cases among detainees, and are they consistent with established standards of care for infection control and CDC guidelines?
- b. Do MDOC's current practices prevent unnecessary hospitalization and death and slow the spread of COVID-19 in a manner consistent with established standards of care for infection control and CDC guidelines?
- c. Do MDOC's current practices identify and protect high-risk detainees from serious illness and death from COVID-19?

9. In order to answer these questions and formulate my assessment, I have relied on the following information:

- a. MDOC's descriptions of its own COVID-19-related policies and practices, including those on and linked to its "COVID-19 Information and Updates" webpage, including the pages titled, "COVID-19 Confirmed Inmate Cases" and

“COVID-19 Questions and Answers,” which describes the measures MDOC has taken to “ensure the well-being of staff and inmates”;³

- b. Declarations of people currently detained by MDOC, including Daniel Hatten (CMCF), Jamarcus Davis (SMCI), Roger Ewing (CMCF), Bob Henderson (SMCI), Thomas Holder (SMCI), Tony Smith (CMCF), Erik Lewis (SMCI), Oziel Guzman (SMCI), Brent Ryan (SMCI), Derrick Guyton (Parchman hospital unit), Douglass Triplett (SMCI), Brittany Waddell (CMCF).

III. STATUS OF COVID-19 CASES AND TESTING IN MDOC FACILITIES

10. As of May 1, 2020, MDOC had 18,132 men and women in custody.⁴ As of May 22, 2020, MDOC had tested 68 inmates, representing 0.3% of its population in custody.⁵ Testing has resulted in 21 documented cases of COVID-19 among inmates in the MDOC system as of May 20, 2020.⁶ One death has been reported among inmates from COVID-19.⁷ I have not found information about the number of hospitalizations of inmates to date due to COVID-19.

³ MDOC maintains a webpage with “COVID-19 Information and Updates,” which includes the link to its “COVID-19 Q&A” and its “Confirmed Cases” listing the location of inmates testing positive for COVID-19. *See, e.g.*, Appendix 2, which includes for May 18, 2020 the set of (1) the main “COVID-19 Information and Updates” page along with the linked-to (2) “COVID-19 Questions and Answers” and (3) “COVID-19 Confirmed Inmate Cases” pages (MDOC COVID-19 Main Page, Q&A, and Confirmed Inmate Cases, May 18, 2020).

⁴ May 2020 Fact Sheet, MDOC, available at <https://www.mdoc.ms.gov/Admin-Finance/MonthlyFacts/2020-5%20Fact%20Sheet.pdf>.

⁵ *See* Appendix 4, COVID-19 Questions and Answers, Miss. Dept. of Corr. (updated May 22, 2020) (citing practices necessary to “ensure the well-being of staff and inmates”) (“COVID-19 Q&A, May 22, 2020”).

⁶ *See* Appendix 3, COVID-19 Questions and Answers, Miss. Dept. of Corr. (updated May 21, 2020) (citing practices necessary to “ensure the well-being of staff and inmates”) (“COVID-19 Q&A, May 21, 2020”).

⁷⁷ Jimmie E. Gates, *Mississippi Inmate Who Died Tested Positive for COVID-19*, Clarion Ledger (Apr. 13, 2020), available at <https://www.clarionledger.com/story/news/2020/04/13/first-confirmed-case-covid-19-state-inmate/2986782001/>.

11. The state of Mississippi has reportedly tested about 51,000 people to date, or approximately 1.7% of its population.⁸ Of those tested, approximately 26% (roughly 13,005 people) have received positive test results.⁹

12. The CDC has classified as “High Priority” the testing of symptomatic residents of prisons and jails; only testing of patients in hospitals and healthcare workers share this High Priority classification.¹⁰ Testing of non-incarcerated people with COVID-19 symptoms is categorized by the CDC with a less urgent “Priority” designation. The difference in priority classification results from the CDC’s recognition that the risk of infection and outbreak in a congregative setting is significantly greater than in the community at large.

13. As of May 15, 2020 (as posted on May 18, 2020),¹¹ MDOC had tested 44 inmates, representing 0.2% of its population in custody: 34% (15 tests) were positive; 9% (4 tests) were pending; 80% (35 tests) were negative. As of the same date, MDOC had tested 49 staff: 16% (8 tests) were positive; 4% (2 tests) were pending; 80% (39 tests) were negative.

14. As of May 21, 2020,¹² MDOC had tested 65 inmates, representing 0.3% of its population in custody: 32% (21 tests) were positive; 9% (6 tests) were pending; 58% (38 tests) were negative. As of the same date, MDOC had tested 62 staff: 16% (10 tests) were positive; 15% (9 tests) were pending; 69% (43 tests) were negative.

⁸ See, e.g., Anita Lee, *How Mississippi became a COVID-19 testing leader despite ‘bottlenecks,’ lack of federal help*, SunHerald (May 21, 2020), available at <https://www.sunherald.com/news/coronavirus/article242153426.html>. (reporting that, according to the Mississippi Department of health, the state has tested 51,434 people, or 1.7% of the state’s population).

⁹ *13,005 cases of coronavirus identified by Miss. Dept. of Health; 616 deaths*, WLBT Digital (May 23, 2020), available at <https://www.wlbt.com/2020/05/23/cases-coronavirus-identified-by-miss-dept-health-deaths/>.

¹⁰ *Evaluation and Testing of Coronavirus*, Centers for Disease Control and Prevention, available at <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html> (last visited May 22, 2020).

¹¹ Appendix 2, MDOC COVID-19 Main Page, Q&A, and Confirmed Inmate Cases, May 18, 2020.

¹² See Appendix 3, COVID-19 Q&A, May 21, 2020.

15. As of May 22, 2020,¹³ MDOC had tested 68 inmates, representing 0.3% of its population in custody: 34% (23 tests) were positive; 7% (5 tests) were pending; 59% (40 tests) were negative. As of the same date, MDOC had tested 72 staff: 15% (11 tests) were positive; 25% (18 tests) were pending; 60% (43 tests) were negative. It is notable that MDOC tested ten staff within the most recent 24-hour period, all of which are pending. A quarter of all tests for MDOC staff are currently pending.

16. MDOC states that, “Symptomatic inmates with fever are tested according to Mississippi State Department of Health and CDC guidelines,” and that “[inmates] will be quarantined, according to MSDH and CDC guidelines.”¹⁴

17. The current many-fold difference—of nearly six times—between the percentage of the population tested in the community versus the prisons in Mississippi reveals a systemic and dramatic failure at either or both stages of (1) symptom identification (through passive and active surveillance measures); and (2) reliable application of the state of Mississippi’s own criteria for COVID-19 testing at the stage when qualifying symptoms are identified.

18. A high percentage of positive tests may indicate that MDOC is overwhelmed by COVID-19, but it may also indicate that not enough testing is being conducted..¹⁵ This is because more positive results means the tests are being used mainly to confirm obvious cases, rather than to determine the full scope of infection in the population, which is likely much larger.¹⁶ The sample

¹³ See Appendix 4, COVID-19 Q&A, May 22, 2020.

¹⁴ See Appendix 3, COVID-19 Q&A, May 21, 2020.

¹⁵ See, e.g., Pien Huang, *If Most of Your Coronavirus Tests Come Back Positive, You’re Not Testing Enough*, Npr.org, available at <https://www.npr.org/sections/coronavirus-live-updates/2020/03/30/824127807/if-most-of-your-coronavirus-tests-come-back-positive-youre-not-testing-enough>.

¹⁶ *Id.*; see also, e.g., Roz Plater, *As Many as 50 Percent of People with COVID-19 Aren’t Aware They Have the Virus*, Healthline (Apr. 24, 2020), available at <https://www.healthline.com/health-news/50-percent-of-people-with-covid19-not-aware-have-virus>.

size of days I have analyzed and overall tests MDOC has completed may be too small to draw clear conclusions; however, preliminarily, the relatively high percentage of positive test results in the MDOC system, combined with the obvious deficiencies I outline below in the MDOC efforts to identify people who have COVID-19 symptoms, suggests that only obviously symptomatic individuals are being tested, and that the rate of infection is actually much higher among inmates and staff. Also of note is that inmates are being tested at a substantially lower rate than staff. And although staff are being tested with greater frequency, the relatively low percentage of negative staff test results indicates that MDOC may also be undertesting its staff as well.¹⁷ In the community, Mississippi's testing program generates an average negative rate of 75%. Among MDOC's staff, the negative testing rate has been as low as 60%, and among MDOC's inmates, the negative testing rate has been as low as 59%.

19. In sum, this data, and the gross deficiencies I note below, provide strong preliminary evidence that MDOC testing practices are systematically deficient. It is likely that the number of COVID-19 cases confirmed by MDOC in its inmate population is significantly lower than the actual number of COVID-19 cases in MDOC's inmate population. Even if this is not the case, the data reported by MDOC shows a clear and dangerous trend: Confirmed COVID-19 cases are rapidly rising in both staff and inmate populations. Because MDOC COVID-19 practices are deficient, as explained further, it is my opinion that cases of COVID-19 infection among both staff

¹⁷ See Johns Hopkins University & Medicine, *Which U.S. States Meet WHO Recommended Testing Criteria?*, JHU Coronavirus Resource Center, available at <https://coronavirus.jhu.edu/testing/testing-positivity> ("If a positivity rate is too high, that may indicate that the state is only testing the sickest patients who seek medical attention, and is not casting a wide enough net to know how much of the virus is spreading within its communities.").

and inmates will continue to rapidly increase absent immediate implementation of measures sufficient to minimally manage and slow the spread of COVID-19.

IV. OBSERVATIONS

20. MDOC's descriptions of its own COVID-19-related policies and practices¹⁸ present the following additional concerns relating to MDOC's COVID-19 response.

21. Identification and response to people with COVID-19 symptoms:

- a. MDOC policies mention screening of staff for signs and symptoms of COVID-19 but make no mention of screening for inmates, whether newly arrived or incarcerated before the onset of COVID-19.
- b. MDOC policies mention that inmates with respiratory symptoms are being seen in a "timely manner" but fail to note whether this is within 24 hours or not.

22. Implementation of infection control and social distancing:

- a. MDOC policies mention increased access to cleaning products but fail to state that every person has access to cleaning products, soap, paper towels and other basic elements of infection control.
- b. MDOC policies mention that information on social distancing has been distributed, but fail to mention whether social distancing is being implemented in its facilities.

23. Identification and protection of high-risk patients:

- a. There is no mention in MDOC documents about whether they have adopted the CDC criteria for who is at high risk for serious illness or death from COVID-19 infection or whether any special precautions are in place for this group of inmates.¹⁹

¹⁸ See, e.g., Appendices 2, 3, 4.

¹⁹ *People Who are at a Higher Risk for Severe Illness*, Centers for Disease Control and Prevention, available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html> (last visited May 22, 2020).

24. The declarations I have reviewed present the following concerns relating to MDOC's COVID-19 response.

25. Identification and response to people with COVID-19 symptoms:

- a. Lack of timely response to sick call requests.
- b. Inmates are unaware of any waiver of the co-pay charge for medical care.
- c. Prolonged time to symptom identification due to short staffing of security personnel.
- d. Lack of response to urgent medical issues due to short staffing of security personnel.
- e. Lack of COVID-19 testing of people with multiple signs and symptoms of infection.
- f. Lack of use of quarantine for staff and inmates who have contact with people infected with COVID-19.
- g. Lack of medical isolation for inmates with known or suspected COVID-19.
- h. Lack of screening or any active surveillance of COVID-19 in housing areas.

26. Implementation of infection control and social distancing including:

- a. Lack of any effort to implement social distancing during pill call, meals, and other congregate situations.
- b. Lack of social distancing in sleeping arrangements.
- c. Lack of soap and towels for hand washing.
- d. Lack of cleaning supplies for cells and bunkbed living areas, leaving inmates to rely on black market access.
- e. Lack of cleaning supplies for common areas.
- f. Inmates make and launder rags themselves for cleaning.
- g. Charging inmates for soap.
- h. Providing soap that damages skin.
- i. Rationing of toilet paper.
- j. Lack of use of masks and other PPE by correctional staff and inmates.
- k. Lack of communication about COVID-19 outbreak.

27. Identification and protection of high-risk patients:

- a. Housing high-risk patients with others in general population.
- b. Patients who are high-risk are not screened for symptoms of COVID-19.
- c. Lack of social distancing in pill line disproportionately impacts high-risk patients.

V. FINDINGS

28. In assessing the COVID-19 response in MDOC, I have used the three original questions stated at the outset of this report for framing.

a. Do MDOC'S current practices detect the number and severity of COVID-19 cases among staff and detainees and respond in a manner consistent with CDC guidelines and other established clinical standards of care?

29. In addition to the testing issues outlined in the previous section, multiple practices appear to be in place at MDOC that would contribute to systematic lack of detection, treatment, and isolation of COVID-19 cases. The lack of testing is currently a bar to effective and timely identification of COVID-19 cases and to effectively slowing the spread of COVID-19.

30. The lack of systematic screening for symptoms of COVID-19 among detainees is the most obvious contributor to this problem. This problem could be remedied by employing COVID-19 symptom and temperature checks for all detainees at least daily, and at a minimum, for all high-risk detainees daily, in a manner consistent with CDC guidance.²⁰

31. The difficulty initiating the sick call process and the length of time it takes to result in an appointment results in people with COVID-19 symptoms not coming to the attention of health staff. The case of Mr. Jamarcus Davis exemplifies these deficiencies. He reports being in an open bay dorm unit with approximately 100 other men when he became ill with cough, fever, and cold sweats. He submitted a sick call slip based on these issues and was not seen for several days. When he was finally seen, he reports that "They checked my temperature and said I had a fever. They asked how I was feeling and I could barely talk because of all the coughing." He

²⁰ *Symptoms of Coronavirus*, Centers for Disease Control and Prevention, available at <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html> (last visited May 22, 2020).

reports being prescribed cold medicine and returned to his unit without any COVID-19 or other testing. He reports spending the following days in his bed, in extremely close quarters with others and that “Whatever I had spread like wildfire in the zone” and that “I do not know anyone who went to the infirmary because of this illness or was tested for the flu or for coronavirus, and we all talked about how sick we were.” This reported lack of response to sick call slips submitted for COVID-19 symptoms is consistent across many of the declarations I reviewed.

32. To prevent unnecessary severe illness of a symptomatic patient and unnecessary infection of healthy inmates housed with a symptomatic patient, sick call requests should result in a clinical assessment within 24 hours according to basic correctional health standards of care.²¹ Currently, MDOC states that its policy is to provide inmates with a face-to-face triage within 24 hours of submitting a sick call slip.²² As discussed in the sections that follow, the declarations I reviewed support that this is not happening.

33. Waiting even 24 hours between reporting of symptoms and evaluation can substantially increase the risk of preventable hospitalization for the patient, particularly if he or she is at-risk according to CDC guidance. This is because coronavirus can cause infections and other complications, which if left untreated, could result in the rapid and irreversible deterioration of health.²³ Patients with underlying conditions are at particular risk for organ failure, which for some, could fully manifest over the span of a week.²⁴ One study found that 17% of their subjects developed Acute Respiratory Distress Syndrome shortly after the first onset of COVID-19

²¹ Ideally, sick call requests regarding coronavirus symptoms should also be copied into a facility tracking tool to better understand the extent and progress of the outbreak.

²² See, e.g., Appendix 3, COVID-19 Q&A, May 21, 2020.

²³ See, e.g., Sevim Zaim, et. al, COVID-19 and Multi-Organ Response, *Current Problems in Cardiology*, Elsevier (Apr. 28, 2020), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7187881/>.

²⁴ *Id.*

symptoms, and among those, 65% rapidly worsened and died from multiple organ failure.²⁵ As a result, the sick call system of any correctional setting must be supplemented with once-daily screenings of all inmates, particularly those who are at high risk of serious illness or death from COVID-19. This represents a combination of active and passive surveillance for COVID-19 symptoms, relying on the active process of screenings and the passive process of sick call.

34. Waiting even 24 hours between reporting of symptoms and isolation can substantially increase the risk of unnecessarily infecting scores of individuals housed with the symptomatic person. Recent studies show that people infected with coronavirus can spread aerosolized viral particles as they cough, breath, or talk in a 13 foot radius, and that those particles can remain in the air for up to 14 minutes, exposing other people to infection.²⁶ Accordingly, failure to immediately isolate an inmate with symptoms results in the continual exposure of people housed in the same space to the virus. Studies also confirm that people with COVID-19 may be infectious days before symptoms appear, meaning that even by the time they report their symptoms, many more people may already have been infected.²⁷ A rapid response is critical to preventing further spread.

35. For adequate reporting through the sick call process to function as a means of infection prevention, inmates and staff both need to be trained on an ongoing basis as to what the

²⁵ *Id.*

²⁶ See, e.g., E.J. Mundell, *Exhaled 'aerosols' spread coronavirus up to 13 feet—and shoes carry the virus, too*, Medical Express (April 17, 2020), available at <https://medicalxpress.com/news/2020-04-exhaled-aerosols-coronavirus-feetand-virus.html>; Knvul Sheikh, *Talking Can Generate Coronavirus Droplets That Linger Up to 14 Minutes*, NY Times (May 14, 2020), available at <https://www.nytimes.com/2020/05/14/health/coronavirus-infections.html>.

²⁷ See, e.g., Kelly MacNamara, *People with COVID-19 may be infectious days before symptoms: study*, Medical Express (April 15, 2020), available at <https://medicalxpress.com/news/2020-04-people-covid-infectious-days-symptoms.html>.

symptoms of COVID-19 are. As discussed in the sections that follow, the declarations I reviewed support that this is not happening.

36. Anyone with more than one COVID-19 symptom and/or sign should be offered testing.

37. Another element to the likely significant undercounting of COVID-19 cases is the ongoing belief that sick call requires a co-pay by inmates. MDOC has stated on their website that the sick call fee for COVID-19 symptoms is waived during the pandemic. In the declarations that I reviewed, inmates consistently reported that they were unaware of any waiver and that the co-pay remained an ongoing disincentive to reporting COVID-19 symptoms. As Mr. Hatten reported, “Some people would not want to go to medical because of the six dollar sick call charge.” Mr. Lewis reported the same: “A lot of people can’t even afford six dollars. Six dollars is two bars of soap, 5-6 meals; it’s a lot of money.”

38. None of the declarants whose statements I reviewed were aware that the sick call charge had been waived or had heard anything about this change. Because of the difficulties that I have seen arise in trying to parse retroactively whether a sick call request was for a COVID-19-related symptom or not, the most effective means I have seen so far to ensure copays do not disincentivize symptom reporting is to waive all medical visit copays during the pandemic. However, this is not required by CDC guidance, so merely informing inmates of the current policy would satisfy the baseline measure.

39. It is apparent that MDOC has significant deficiencies in the care of people who are identified as having COVID-19 symptoms. People who submitted declarations report that when a person became ill with COVID-19 symptoms, they were returned to their original housing area without COVID-19 testing. When quarantine is implemented, it appears that MDOC does not

follow basic CDC guidelines. Mr. Henderson reported that in his building, an inmate became ill and that housing area was placed in quarantine, with the sick inmate still inside the housing area. He said, “They did not move the inmate from the zone, just quarantined the whole building.” This practice violates basic principles of infection control and CDC guidelines, since a quarantine is meant for people who were in contact with a known or suspected case of COVID-19, and medical isolation is where any known or suspected case should be taken immediately, so as to lower the risk of transmission to others. Ms. Waddell talked about her quarantine, “A couple of weeks ago, an officer opened the door to the zone, yelled that we were quarantined for fourteen days, and shut the door. We weren’t told anything more. Only later did we happen to learn from a guard that another guard who had been on our zone had coronavirus symptoms.” Ms. Waddell continued, “During the fourteen-day quarantine period, we had our temperature checked a total of three times.”

40. In addition to addressing the systematic barriers to meeting its own policy of responding to sick call requests within 24 hours, MDOC must institute an active surveillance program that checks every inmate for signs and symptoms of COVID-19 on a daily basis, especially high-risk inmates. Implementation of this process will actually reduce the need for sick call requests and will increase the access to care for people with COVID-19 and decrease the time that their illness progresses from mild to severe stages.

b. *Do MDOC’S current practices slow the spread of COVID-19 through the facility and between people, both staff and detainees, in a manner consistent with CDC guidelines and other clinical standards of care?*

41. The infection control practices in MDOC reveal multiple deficiencies that ignore CDC guidelines for responding to COVID-19 in detention settings.²⁸ A lack of cleaning solution in the housing areas is widely reported in the declarations I reviewed. Mr. Henderson reports, “We do not have enough cleaning supplies from MDOC to clean all of the common areas.” He adds that “Workers use their own rags that we make from our towels to apply the chemicals to clean common surfaces.” Mr. Lewis similarly said the cleaning liquid is “not enough to clean everything in the common areas. We have to clean certain things and not others. We use torn up sheets and towels to apply this [cleaning] liquid.”

42. Even more concerning is the report by multiple people that the lack of access to cleaning supplies has given rise to a black market for these CDC-mandated elements of COVID-19 infection control. Mr. Davis reports “It’s possible to buy or trade others for these cleaning supplies, but that is not something many people can afford or want to do. Residents would clean their living spaces if given the opportunity; people are afraid of the coronavirus. They are never enough chemicals to go around to daily sanitize.” Mr. Lewis similarly reported, “I trade food for extra soap, so I can keep my space clean. I’ve traded food, canteen, a towel to get disinfectant. This kind of bartering is not possible for many people. One missed meal would be devastating for some people because they are barely hanging on.” Ms. Waddell said, “If you want to clean your rack area yourself, there are rarely any chemicals available because cleaning chemicals meant for

²⁸ “Prevention” *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#prevention> (last visited May 22, 2020).

the zone are often not used for that purpose; they are instead diverted and sold or traded for profit.” These reports are even more concerning in light of MDOC’s refusal to guarantee that inmates will receive an adequate supply of cleaning materials, and instead simply states that “Additional cleaning has occurred.”²⁹

43. A lack of soap and paper towels to dry hands is also reported in many of these declarations. Mr. Henderson reports that “The only reason I have enough soap to regularly wash my hands and shower is that I have family support, so I’m able to buy additional soap from commissary.” The lack of cleaning chemicals exacerbates the lack of soap. Mr. Lewis reported, “We are not being provided with chemicals to clean these [bunk] areas. I try to clean my bunk area with the Dial soap and water and use a torn sheet or towel to clean.” In addition, the soap is used to clean clothes. Ms. Waddell for example said, “We have to wash our clothes with the same soap they give us to wash our hands and bodies. If you don’t have money from the outside on your books, you would not have enough soap to keep clean from what the state provides. I have family support to buy soap from canteen, but many don’t.”

44. A lack of social distancing in sleeping arrangements, lines for services, day rooms and meals was widely reported in the declarations I reviewed. As Mr. Hatten reported, “When we are in the dayroom having dayroom call or eating, we do not sit with extra space between us and we do not sit six feet apart. No one had told us to do so.” Mr. Lewis similarly said, “There is no such thing as social distancing in this prison. We don’t even hear that word. That is not practiced here. No one tells us we need to stand six feet apart. There is no one practicing social distancing anywhere in the zone or at the ILAP office or anywhere else I’ve seen in the facility.” Mr. Triplett

²⁹ See Appendix 3, COVID-19 Q&A, May 21, 2020.

agreed, “There are no social distancing efforts being taken in this zone or this facility that I’ve seen. When we go to medical, they pile us in one room. When we see the nurse, there is no social distancing.” Ms. Waddell reported, “There is no way to maintain six feet of distance between us anywhere on the zone. Even if you try to avoid physical contact, there is no way to avoid it. If I try to make it to one side of the zone to the other to go to the bathroom, it’s like trying to get through a herd of cattle to get to the gate. You have to walk sideways through packs of people pushing through. Especially when it is tray time, everyone is trying to get through each other.”

45. There also appears to be little effort to implement wearing of masks inside housing areas, and detainees report ongoing practices of close contact when they are outside their housing areas, often with detainees from other pods. Mr. Davis reported that “Many officers still walk around the zone without a mask or gloves. Some officers who do wear masks only wear them halfway on their face or just around their neck.” Mr. Lewis said, “Officers don’t take this seriously. Some have their mask on, some have it half way on, most don’t wear it at all. They are putting us at risk.” Mr. Triplett reported, “Not many people – whether staff or incarcerated people – wear them [masks] whether they are in the Zone or outside the Zone. When I went to the ILAP office, one of the women did not have a mask on. The Captain visited the Zone on May 11, and he didn’t have a mask on.” Ms. Waddell said, “One of the officers who was quarantined for fourteen days came back to work without her mask on. Residents on the zone asked her to put a mask on and she did not. She continues to not wear a mask when she is on the zone.” MDOC staff appear to have actually prohibited some inmates from wearing the very same masks that were issued to some of them recently. Mr. Ewing reported that “The day after we received the masks, the staff member over our building announced to our zone that we are forbidden to wear the masks in the building because guards cannot identify men on camera if they are wearing a mask.”

46. These deviations from clear CDC guidelines place staff at risk alongside inmates. Mr. Davis reported “I have never witnessed staff cleaning equipment they share with other staff.” I would expect, as MDOC’s numbers prove, that the infection rate among staff members discussed in the previous section reflect the increased risk to which they are exposed because of MDOC’s lack of attention to basic infection control in its facilities.

c. Do MDOC’S current practices identify and protect high-risk detainees from serious illness and death from COVID-19?

47. It appears that little effort has been made to identify and protect high-risk inmates in the custody of MDOC. Many of the declarations I reviewed were submitted by people who meet CDC criteria for being at high risk of serious illness or death from COVID-19, and none of them were receiving daily or even regular symptom and temperature checks for COVID-19.

48. The lack of any social distancing during pill call is a deficiency that disproportionately harms high-risk patients. Many of the declarations I reviewed mentioned this issue. Mr. Henderson reported that “When the nurse comes for pill call, nobody lines up six feet apart. No one instructed us to do so. We all pile at the door.” Since people receiving medications are more likely to be in the subset of people the CDC identifies as high-risk, they bear an additional risk of exposure to COVID-19 because MDOC does not implement social distancing in this setting. Mr. Holder reports that even in his unit which is heavily concentrated with high-risk patients like himself, “When nurses come on the zone for pill call and insulin call, nobody lines up six feet apart. No one has told us to stand six feet apart.” The lack of social distancing and other precautions also occurs during medical visits. Ms. Waddell reported, “When we are taken to see medical staff, we are brought in large groups by a shuttle van to the reception center and placed in holding tanks together, then taken out of the holding tank one by one to see medical staff. Today, I was held in

a holding tank for about forty-five minutes with ten other people waiting. The holding tank was about ten feet by ten feet, at the most, with solid walls, a solid door, no window that opens, and no ventilation. One lady in there would not stop coughing. She was taking her mask on and off. Not all of the other residents had their masks on. As I was leaving, more residents were coming from the van to go into that holding tank. The officers working in the reception center were not wearing their masks or were wearing them on their chin.”

49. High-risk patients should be identified using CDC criteria, should be offered testing for COVID-19, and placed into housing areas with increased levels of infection control and twice daily symptom and sign checks. Frequent monitoring and protection of these individuals is necessary because they face a disproportionately high risk of rapid organ damage or failure, blood clots, pneumonia, additional viral and bacterial infections, and other severe COVID-19-related complications which require immediate medical treatment.³⁰

50. Many of the deficiencies and deviations from CDC guidelines in MDOC’s response to COVID-19 appear linked to the lack of staffing. The declarations I reviewed reported that basic security functions do not occur and that extremely dangerous and harmful practices occur because of a lack of staffing. Mr. Davis reported that “Once for two months we were locked in our cells and never let out: no showers, no yard, no dayroom. We washed our bodies out of a sink for two months. It was very difficult. I am terrified that is what they will do to us if we get sick and the guards stop coming to work.” Others reported that this has been a pressing issue during the COVID-19 pandemic. Mr. Roger Ewing reported that “These days, sometimes there are zero

³⁰ See Coronavirus disease 2019 (COVID-19), Symptoms & causes, Mayo Clinic, *available at* <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963> (visited on May 23, 2020).

officers—none in the tower and none on the zone—for many hours at a time, even for an entire shift, which is twelve hours. When staff are on duty, there is usually only one guard in the tower to oversee all 200 individuals” and added that on weekends and evenings, there is no relief when one guard leaves, meaning that one guard is covering 400 residents. Ms. Waddell similarly reported, “When I was housed in D-Zone, it was not uncommon to have no officers anywhere in the tower or on the zone for entire shifts. A shift is twelve hours.” Mr. Triplett added, “I’ve seen guards stay at work so long, they walk off the job and leave the tower unattended. Some guards have to work two buildings, leaving one building of 200 people unattended for hours at a time.” Even when present, “Some officers cover the windows, so she can’t see us and we can’t see them,” reported Mr. Lewis. Mr. Triplett agreed, “The tower guards frequently paper over the windows, so no one can see in or out. For the night shift, sometimes they will paper over the windows for the whole night.”

51. This lack of staffing or responsive staff renders it impossible for MDOC to meet its basic obligations to respond to medical emergencies and coordinate access to sick call and other health services. Mr. Ewing reported, “I myself have severe asthma attacks that I can die from. Medical staff have directed me to come straight to the clinic as soon as I feel one coming on. I have tried to do as medical staff have directed and failed because no tower officer-no officer at all-was watching the 400 of us. Those times I have had to ride the asthma attack out, barely able to breathe. I’ve been lucky so far.” Mr. Lewis made similar remarks, “We have to set fires, almost knock the door down to get medical attention. It all depends on the tower officer. If she wants to, or is in the right mood, you may or may not get help.” Mr. Lewis continued, “I have seen someone die from a stroke and SMCI did not respond in time. It took them 40 minutes to come, and they took him out dead. After the tower officer made the call, she just sat there and did nothing more.”

Mr. Triplett told a similar story: “a guy had chest pains, like a heart attack, and we needed to call an officer and get medical attention, but there was no staff present. We had to kick on the door to see if we could get someone walking by on the sidewalk.” Ms. Waddell also reported, “In about April of this year, a pregnant lady’s water broke in the bathroom on D-Zone where I lived. . . . Some other residents pulled the pregnant lady’s bed into the bathroom by the toilet after her water broke because there was no staff to get medical help. It was terrifying. The only way we finally got medical staff to come help her was after all of the about one hundred women on that zone all started screaming as loud as we could and beating on the walls and banging on the windows facing the Shift Command building. Finally, someone heard us. Guard staff came into the building and wheeled her out on a wheelchair.”

52. This lack of staffing and responsive staff also blocks sick call access. Mr. Henderson reported, “To fill out a sick call slip, a tower officer has to be present. I have to ask him or her to give me a sick call slip. If they give me one, I fill it out. I may have to wait a day to be able to submit it.” At times, there is no way to submit a sick call form because the forms ran out. Mr. Lewis reported, “A lot of times, especially during cold and flu season, they won’t have any sick call slips. There are no sick calls in the tower now, as I say this, May 7, 2020, because I tried to get one this morning.”

53. The lack of staffing also blocks the Department’s ability to implement basic CDC guidelines for responding to COVID-19. Specifically, the lack of staffing makes distribution and use of cleaning supplies impossible, as well as distribution of soap, hand sanitizer and paper towels. It also leaves the facilities without sufficient staff to create quarantine and medical isolation units once people become ill, which are necessary approaches clearly detailed by the CDC.

VI. CONCLUSION: MDOC'S RESPONSE TO COVID-19 AT CMCF AND SMCI IS DEFICIENT.

54. My preliminary assessment of the COVID-19 response by MDOC is that the Department has failed to enact basic CDC guidelines aimed at preventing the spread of COVID-19 and protecting staff and detained people from serious illness and death. The lack of adequate staffing in MDOC facilities has created a dangerous inability of MDOC to effectively implement COVID-19 prevention and management protocols consistent with established standards of care for infection control and CDC guidelines; these implementation gaps are highly likely to result in preventable loss of life among staff and inmates. The failures of MDOC's COVID-19 response fall into the following categories:

- a. Failure to detect the number and severity of COVID-19 cases among staff and detainees and respond in a manner consistent with established standards of care for infection control and CDC guidelines.
- b. Failure to slow the spread of COVID-19 through the facility and between people, both staff and detainees, in a manner consistent with established standards of care for infection control and CDC guidelines.
- c. Failure to identify and protect high-risk detainees from serious illness and death from COVID-19.

55. In addition to increasing the risk of preventable illness and death from COVID-19, these deficiencies create an imminent risk that more hospitalizations occur as patients become ill without early intervention, which can swiftly overwhelm local hospitals already struggling to care for COVID-19 patients.³¹

³¹ See, e.g., Chuck Goudie et al., *Illinois prisoners sick with COVID-19 "overwhelm" Joliet hospital*, ABC 7 (Mar. 30, 2020), available at <https://abc7chicago.com/health/illinois-prisoners-sick-with-covid-19-overwhelm-joliet-hospital/6064085/>.

Executed this 24th day in May 2020 in Port Washington, New York:



Homer Venters MD, MS

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APPENDIX 1

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HEALTH ADMINISTRATOR

PHYSICIAN

EPIDEMIOLOGIST

Professional Profile

- International leader in provision and improvement of health services to patients with criminal justice involvement.
- Innovator in linking care of the incarcerated to Medicaid, health homes, DSRIPs.
- Successful implementer of nations' first electronic health record, performance dashboards and health information exchange among pre-trial patients.
- Award winning epidemiologist focused on the intersection of health, criminal justice and human rights in the United States and developing nations.
- Human rights leader with experience using forensic science, epidemiology and public health methods to prevent and document human rights abuses.

Professional Experience

Medical/Forensic Expert, 3/2016-present

- Review COVID-19 policies and procedures in detention settings.
- Conduct analysis of health services and outcomes in detention settings.
- Conduct site inspections and evaluations in detention settings.
- Produce expert reports, testimony regarding detention settings.

President, Community Oriented Correctional Health Services (COCHS), 1/1/2020-4/30/20.

- Lead COCHS efforts to provide technical assistance, policy guidance and research regarding correctional health and justice reform.
- Oversee operations and programmatic development of COCHS
- Serve as primary liaison between COCHS board, funders, staff and partners.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), 12/1/18-12/31/2018

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.

- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model to a new division within NYCH + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately \$5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from \$140 million to \$160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from \$115 million to \$140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine,
1/08-11/09.

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009

Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.

Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University 7/2004- 5/2007.

M.D., University of Illinois, Urbana, 12/2003.

M.S. Biology, University of Illinois, Urbana, 6/03.

B.A. International Relations, Tufts University, Medford, MA, 1989.

Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health,
5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.

M.D. New York (2007-present).

Media

TV

i24 Crossroads re Suicide in U.S. Jails 8/13/19.

i24 Crossroads re *Life and Death in Rikers Island* 6/13/19.

Amanpour & Company, NPR/PBS re *Life and Death in Rikers Island* 4/15/19.

CNN, Christiane Amanpour re Forensic documentation of mass crimes against Rohingya.
7/11/18.

i24 Crossroads with David Shuster re health crisis among refugees in Syria. 7/6/18.

Canadian Broadcasting Corporation TV with Sylvie Fournier (in French) re crowd control weapons. 5/10/18

i24 Crossroads with David Shuster re Cholera outbreak in Yemen. 2/15/18.

China TV re WHO guidelines on HIV medication access 9/22/17.

Radio/Podcast

Morning Edition, NPR re Health Risks of Criminal Justice System. 8/9/19.

Fresh Air with Terry Gross, NPR re *Life and Death in Rikers Island*, 3/6/19.

Morning Edition, NPR re *Life and Death in Rikers Island*, 2/22/19.

LeShow with Harry Sherer re forensic documentation of mass crimes in Myanmar, Syria, Iraq. 4/17/18.

Print articles and public testimony

Oped: Four ways to protect our jails and prisons from coronavirus. *The Hill* 2/29/20.

Oped: It's Time to Eliminate the Drunk Tank. *The Hill* 1/28/20.

Oped: With Kathy Morse. A Visit with my Incarcerated Mother. *The Hill* 9/24/19.

Oped: With Five Omar Muallim-Ak. The Truth about Suicide Behind Bars is Knowable. *The Hill* 8/13/19.

Oped: With Katherine McKenzie. Policymakers, provide adequate health care in prisons and detention centers. *CNN Opinion*, 7/18/19.

Oped: Getting serious about preventable deaths and injuries behind bars. *The Hill*, 7/5/19.

Testimony: Access to Medication Assisted Treatment in Prisons and Jails, New York State Assembly Committee on Alcoholism and Drug Abuse, Assembly Committee on Health, and Assembly Committee on Correction. NY, NY, 11/14/18.

Oped: Attacks in Syria and Yemen are turning disease into a weapon of war, *STAT News*, 7/7/17.

Testimony: Connecticut Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for prisoners. Hartford CT, 2/3/17.

Testimony: Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Oped: Venters HD and Keller AS, The Health of Immigrant Detainees. *Boston Globe*, April 11, 2009.

Testimony: U.S. House of Representatives, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

Peer Reviewed Publications

Parmar PK, Leigh J, **Venters H**, Nelson T. Violence and mortality in the Northern Rakhine State of Myanmar, 2017: results of a quantitative survey of surviving community leaders in Bangladesh. *Lancet Planet Health*. 2019 Mar;3(3):e144-e153.

Venters H. Notions from Kavanaugh hearings contradict medical facts. *Lancet*. 10/5/18.

Taylor GP, Castro I, Rebergen C, Rycroft M, Nuwayhid I, Rubenstein L, Tarakji A, Modirzadeh N, **Venters H**, Jabbour S. Protecting health care in armed conflict: action towards accountability. *Lancet*. 4/14/18.

Katyal M, Leibowitz R, **Venters H**. IGRA-Based Screening for Latent Tuberculosis Infection in Persons Newly Incarcerated in New York City Jails. *J Correct Health Care*. 2018 4/18.

Harocopos A, Allen B, Glowa-Kollisch S, **Venters H**, Paone D, Macdonald R. The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated. *J Health Care Poor Underserved*. 4/28/17.

MacDonald R, Akiyama MJ, Kopelow A, Rosner Z, McGahee W, Joseph R, Jaffer M, **Venters H**. Feasibility of Treating Hepatitis C in a Transient Jail Population. *Open Forum Infect Dis*. 7/7/18.

Siegler A, Kaba F, MacDonald R, **Venters H**. Head Trauma in Jail and Implications for Chronic Traumatic Encephalopathy. *J Health Care Poor and Underserved*. In Press (May 2017).

Ford E, Kim S, **Venters H**. Sexual abuse and injury during incarceration reveal the need for re-entry trauma screening. *Lancet*. 4/8/18.

Alex B, Weiss DB, Kaba F, Rosner Z, Lee D, Lim S, **Venters H**, MacDonald R. Death After Jail Release. *J Correct Health Care*. 1/17.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Kopelow A, Litwin AH, **Venters H**, MacDonald R. Correlates of Hepatitis C Virus Infection in the Targeted Testing Program of the New York City Jail System. *Public Health Rep*. 1/17.

Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, **Venters H**. Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System. *J Correct Health Care*. 2016 Oct;22(4):383-392.

Venters H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *Am J Public Health*. April 2016.104.

Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, **Venters H**. From Punishment to Treatment: The “Clinical Alternative to Punitive Segregation” (CAPS) Program in New York City Jails. *Int J Env Res Public Health*. 2016. 13(2),182.

Jaffer M, Ayad J, Tungol JG, MacDonald R, Dickey N, Venters H. Improving Transgender Healthcare in the New York City Correctional System. *LGBT Health*. 2016 1/8/16.

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. *Int J Env Res Public Health*. 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, **Homer Venters**. Meaningful Use of an Electronic Health Record in the NYC Jail System. *Am J Public Health*. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Angell, **Homer Venters**. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. *Am J Public Health*. 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Alison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, **Homer Venters**. The Rikers Island Hot Spotters. *Am J Public Health*. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonald, **Homer Venters**. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. *Bulletin of the World Health Organization*. 2015.

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathaniel Dickey, **Homer Venters**. Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System *J Health Care Poor Underserved*. 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, **Venters H**. Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail. *Health and Human Rights*. Online ahead of print, 3/12/15.

Teixeira PA¹, Jordan AO, Zaller N, Shah D, **Venters H**. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. *Am J Public Health*. 2014 Dec 18.

Selling D, Lee D, Solimo A, **Venters H**. A Road Not Taken: Substance Abuse Programming in the New York City Jail System. *J Correct Health Care*. 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, **Venters H**. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. *Am J Public Health*. 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, **Venters H**. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. *Health and Human Rights*. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, **Venters H**. Case series of exercise-induced rhabdomyolysis in the New York City Jail System. *Am J Emerg Med*. 2014. Vol 32(5): 446-7.

Bechelli M, Caudy M, Gardner T, Huber A, Mancuso D, Samuels P, Shah T, **Venters H**. Case Studies from Three States: Breaking Down Silos Between Health Care and Criminal Justice. *Health Affairs*. 2014. Vol. 3. 33(3):474-81.

Selling D, Solimo A, Lee D, Horne K, Panove E, **Venters H**. Surveillance of suicidal and non-suicidal self-injury in the new York city jail system. *J Correct Health Care*. 2014. Apr;20(2).

Kaba F, Diamond P, Haque A, MacDonald R, **Venters H**. Traumatic Brain Injury Among Newly Admitted Adolescents in the New York City Jail System. *J Adolesc Health*. 2014. Vol 54(5): 615-7.

Monga P, Keller A, **Venters H**. Prevention and Punishment: Barriers to accessing health services for undocumented immigrants in the United States. *LAWS*. 2014. 3(1).

Kaba F, Lewsi A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, **Venters H**. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.

MacDonald R, Parsons A, **Venters H**. The Triple Aims of Correctional Health: Patient safety, Population Health and Human Rights. *Journal of Health Care for the Poor and Underserved*. 2013. 24(3).

Parvez FM, Katyal M, Alper H, Leibowitz R, **Venters H**. Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections*. 89:280-284. 2013.

Brittain J, Axelrod G, **Venters H**. Deaths in New York City Jails: 2001 – 2009. *Am J Public Health*. 2013 103:4.

Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, **Venters H**. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *AIDS Behav*. Nov. 2012.

Jaffer M, Kimura C, **Venters H**. Improving medical care for patients with HIV in New York City jails. *J Correct Health Care*. 2012 Jul;18(3):246-50.

Ludwig A, Parsons, A, Cohen, L, **Venters H**. Injury Surveillance in the NYC Jail System, *Am J Public Health* 2012 Jun;102(6).

Venters H, Keller, AS. *Psychiatric Services*. (2012) Diversion of Mentally Ill Patients from Court-ordered care to Immigration Detention. Epub. 4/2012.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2011) Mental Health Concerns Among African Immigrants. 13(4): 795-7.

Venters H, Foote M, Keller AS. *Journal of Immigrant and Minority Health*. (2010) Medical Advocacy on Behalf of Detained Immigrants. 13(3): 625-8.

Venters H, McNeely J, Keller AS. *Health and Human Rights*. (2010) HIV Screening and Care for Immigration Detainees. 11(2) 91-102.

Venters H, Keller AS. *Journal of Health Care for the Poor and Underserved*. (2009) The Immigration Detention Health Plan: An Acute Care Model for a Chronic Care Population. 20:951-957.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2009) African Immigrant Health. 4/4/09.

Venters H, Dasch-Goldberg D, Rasmussen A, Keller AS, *Human Rights Quarterly* (2009) Into the Abyss: Mortality and Morbidity among Detained Immigrant. 31 (2) 474-491.

Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

Venters H, Lainer-Vos J, Razvi A, Crawford J, Shaf' on Venable P, Drucker EM, *Am J Public Health* (2008) Bringing Health Care Advocacy to a Public Defender's Office. 98 (11).

Venters H, Razvi AM, Tobia MS, Drucker E. *Harm Reduct J.* (2006) The case of Scott Ortiz: a clash between criminal justice and public health. *Harm Reduct J.* 3:21

Cloez-Tayarani I, Petit-Bertron AF, **Venters HD**, Cavaillon JM (2003) *Internat. Immunol.* Differential effect of serotonin on cytokine production in lipopolysaccharide-stimulated human peripheral blood mononuclear cells. 15, 1-8.

Strle K, Zhou JH, Broussard SR, **Venters HD**, Johnson RW, Freund GG, Dantzer R, Kelley KW, (2002) *J. Neuroimmunol.* IL-10 promotes survival of microglia without activating Akt. 122, 9-19.

Venters HD, Broussard SR, Zhou JH, Bluth RM, Freund GG, Johnson RW, Dantzer R, Kelley KW, (2001) *J. Neuroimmunol.* Tumor necrosis factor(alpha) and insulin-like growth factor-I in the brain: is the whole greater than the sum of its parts? 119, 151-65.

Venters HD, Dantzer R, Kelley KW, (2000) *Ann. N. Y. Acad. Sci.* Tumor necrosis factor-alpha induces neuronal death by silencing survival signals generated by the type I insulin-like growth factor receptor. 917, 210-20.

Venters HD, Dantzer R, Kelley KW, (2000) *Trends. Neurosci.* A new concept in neurodegeneration: TNFalpha is a silencer of survival signals. 23, 175-80.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd, (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd, (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Bonilla LE, Jensen T, Garner HP, Bodayo EZ, Najarian MM, Ala TA, Mason RP, Frey WH 2nd, (1997) Heme from Alzheimer's brain inhibits muscarinic receptor binding via thiyl radical generation. *Brain. Res.* 764, 93-100.

Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

Honors and Presentations (past 10 years)

Keynote Address, Academic Correctional Health Conference, April 2020, Chapel Hill, North Carolina.

TedMed Presentation, Correctional Health, Boston MA, March 2020.

Finalist, Prose Award for Literature, Social Sciences category for *Life and Death in Rikers Island*, February, 2020.

Keynote Address, John Howard Association Annual Benefit, November 2019, Chicago IL.

Keynote Address, Kentucky Data Forum, Foundation for a Healthy Kentucky, November 2019, Cincinnati Ohio.

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails and prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting 10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association Annual Meeting*, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health

Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association*, Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA,

November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association Annual Meeting*, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association Annual Meeting*, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine Annual Meeting*, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine Annual Meeting*, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arrestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine Annual Meeting*, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine Annual Meeting*, Los Angeles CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine Annual Meeting*, New Orleans LA, April 2005.

Grants: Program

San Diego County: Review of jail best practices (COCHS), 1/2020, \$90,000.

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget \$ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget \$250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget \$500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget \$375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget \$280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget \$290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget \$175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget \$290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget \$100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget \$250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, June 2015, June 2014, April 2019.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/05-11/18.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

-*Primary Project*; Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French

-*Secondary Project*; Malaria Prevention.

Books

Venters H. *Life and Death in Rikers Island*. Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement in Jail. In Solitary Confinement Effects, Practices, and Pathways toward Reform. Oxford University Press, 2020.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Membership in Professional Organizations
American Public Health Association

Foreign Language Proficiency

French	Proficient
Ewe	Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. N.D.Tx) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17.

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (WJ/KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO.: 4:16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Hutchinson v. Bates et. al. AL, No. 2:17-CV-00185-WKW- GMB, as expert for plaintiff 3/27/19.

Lewis v. East Baton Rouge Parish Prison LA, No. 3:16-CV-352-JWD-RLB, as expert for plaintiff 6/24/19.

Belcher v. Lopinto, No. 2:2018cv07368 - Document 36 (E.D. La. 2019) as expert for plaintiffs 12/5/2019.

Imoerati v. Semple, U.S. District Court, CT. No 3:18cv01847 (RNC), on behalf of plaintiffs, 3/11/20.

Fee Schedule

Case review, reports, testimony \$500/hour.

Site visits and other travel, \$2,500 per day (not including travel costs).

APPENDIX 2



Home (/Pages/default.aspx) About ▾ (/About/Pages/About.aspx)
 Divisions ▾ (/Divisions/Pages/default.aspx)
 Victim Services & SAVIN ▾ (/Victim-Services/Pages/default.aspx)
 News & Media ▾ (/News/Pages/default.aspx)

Search Inmate Search (<https://www.ms.gov/mdoc/inmate>)

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Area Locations (/About/Pages/Area-Locations.aspx)

Facility Locations (/Pages/Facility-Locations.aspx)

MDOC (/Pages/default.aspx) > COVID-19 Information and Updates

COVID-19 INFORMATION AND UPDATES

In response to developments with COVID-19, the Mississippi Department of Corrections will continue to take action to protect staff, inmates, and the public. The MDOC is committed to ensuring inmates' rights, safety, and health are safeguarded through this process. The department is in constant communications with the Office of the Governor, the Mississippi Department of Health, the Mississippi Emergency Management Agency (MEMA), and other authorities.

COVID-19 Q&A

MDOC Questions and Answers for COVID-19 (/Documents/QA%20version%20without%20intro.pdf)

Confirmed Cases

State, Private and Regional Facilities

(/Documents/Inmates%20cases%20chart.pdf)

Press Releases (/Documents/Press%20Releases%20Regarding%20COVID-19.docx)

April 30

No Contact Reporting to Continue in May

(/News/PressReleases/No%20Contact%20Reporting%20to%20Continue%20in%20May.pdf)

April 29

(/News/PressReleases/Inmates%20Working%20with%20MPIC%20Fight%20Against%20COVID-19.pdf)

Inmates Working with MPIC Fight Against COVID-19

(/News/PressReleases/Inmates%20Working%20with%20MPIC%20Fight%20Against%20COVID-19.pdf)

(/News/PressReleases/Inmates%20Working%20with%20MPIC%20Fight%20Against%20COVID-19.pdf)

April 27 (/News/PressReleases/MDOC%20COVID-19%20Update.pdf)

MDOC COVID-19 Update

(/News/PressReleases/MDOC%20COVID-19%20Update.pdf)

April 16 (/News/PressReleases/MDOC%20Update%20on%20its%20COVID-19%20Response.pdf)

MDOC Update on its COVID-19 Response

(/News/PressReleases/MDOC%20Update%20on%20its%20COVID-19%20Response.pdf)

April 13

MDOC Confirms One COVID-19 Case Among Inmates

(/News/PressReleases/MDOC%20Confirms%20One%20COVID-19%20Case.pdf)

April 1 (/News/PressReleases/People%20on%20Supervision%20to%20Report%20by%20Phone.pdf)

MDOC Asks People on Supervision to Report by Phone in Response to COVID-19

(/News/PressReleases/People%20on%20Supervision%20to%20Report%20by%20Phone.pdf)

March 20 (/News/PressReleases/MDOC%20Adjusts%20COVID-

19%20Prevention%20Response%20for%20Community%20Supervision.pdf)

MDOC Adjusts Reporting for Community Supervision in Response to COVID-19

(/News/PressReleases/MDOC%20Adjusts%20COVID-

19%20Prevention%20Response%20for%20Community%20Supervision.pdf)

March 16

(/News/PressReleases/State%20Phone%20Provider%20Offering%20Free%20Calls%20to%20Inmates.pdf)

Free Inmate Phone Calls Offered by State Phone Provider

(/News/PressReleases/State%20Phone%20Provider%20Offering%20Free%20Calls%20to%20Inmates.pdf)

(/News/PressReleases/MDOC%20Adjusts%20COVID-

19%20Prevention%20Response%20for%20Community%20Supervision.pdf)

(/News/PressReleases/People%20on%20Supervision%20to%20Report%20by%20Phone.pdf)

March 12

(/News/PressReleases/MDOC%20Takes%20Preventative%20Steps%20Against%20Coronavirus%20Exposure.pdf)

MDOC Takes Steps to Protect Staff, Inmates, Public Against Coronavirus Exposure

(/News/PressReleases/MDOC%20Takes%20Preventative%20Steps%20Against%20Coronavirus%20Exposure.pdf)

(/News/PressReleases/MDOC%20Takes%20Preventative%20Steps%20Against%20Coronavirus%20Exposure.pdf)

MDOC Suspends Inmate Transfers as Part of Response to Coronavirus

(/News/PressReleases/Inmate%20Transfers%20Suspended%20in%20Response%20to%20Coronavirus.pdf)

COVID-19 Information and Updates

5/18/20, 5:56 PM

(/News/PressReleases/MDOC%20Adjusts%20COVID-19%20Prevention%20Response%20for%20Community%20Supervision.pdf)
 (/News/PressReleases/MDOC%20Update%20on%20Its%20COVID-19%20Response.pdf)
 (/News/PressReleases/People%20on%20Supervision%20to%20Report%20by%20Phone.pdf)

Governor's Press Conferences (<https://governorreeves.ms.gov/covid-19/>)

This link will re-direct you to Governor Tate Reeves' website. View press releases from his office, videos of his press briefings, and the executive orders he has issued, all regarding COVID-19.

Resources:

The Mississippi Department of Health (https://msdh.ms.gov/msdhsite/_static/14,0,420.html)

The Mississippi Emergency Management Agency (MEMA) (<https://www.msema.org/>)

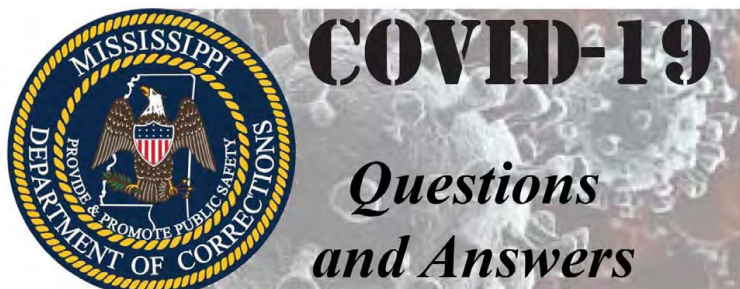
Centers for Disease Control (CDC) (<https://www.cdc.gov/>)

World Health Organization (WHO) (<https://www.who.int/>)

Home (/Pages/default.aspx) | FAQs (/Pages/FAQs.aspx) |
 Links (/Pages/Links.aspx) | Contact Us (/Pages/Contact-
 Us.aspx) | Disclaimer (/Pages/Disclaimer.aspx) |
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 (<https://twitter.com/MSDeptofCorrections>)
 (<http://www.ms.gov>)

301 North Lamar Street, Jackson, MS 39201
 (601) 359-5600



Answers to some of the most frequently asked questions:
Last Update: May 15, 5 p.m.

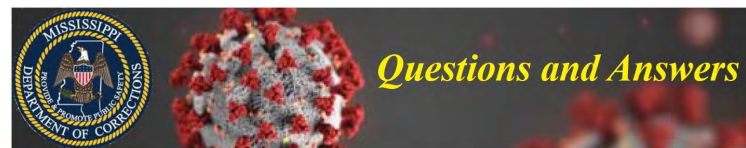
Q-1. What is the Mississippi Department of Corrections doing to ensure the well-being of staff and inmates?

A. The MDOC has provided masks to all inmates and correctional staff. Gloves and additional soap are provided. Hand sanitizer is also available in strategic locations, including dining halls.

Signage has been posted throughout MDOC facilities and handout information has been provided to inmates listing symptoms of COVID-19 and informing them how to protect themselves.

Inmates can access medical staff using the sick call system. A face-to-face triage is completed within 24 hours of submission of the sick call request. Medical staff are seeing inmates with acute respiratory symptoms in a timely manner. Symptomatic inmate patients with fever are tested according to Mississippi State Department of Health and CDC guidelines. They will be quarantined or isolated, according to MSDH and CDC guidelines. Affected patients will receive treatment and support and may be transferred to a community hospital, if symptoms become severe. Security staff and non-security staff are screened daily for elevated temperature. Staff found to have a fever (temperature of 100.4 or above) will not be allowed to report to work that day and will be advised to contact their doctor's office. Information regarding frequent hand washing, cough hygiene, and social distancing has been distributed to staff and inmates.

A screening tool questionnaire has also been implemented for staff arriving at a correctional facility. The questions include asking about recent travel from an affected country and possible exposure to someone who has suspected or confirmed COVID-19 disease.



Q-2. How many confirmed cases are in the inmate population?

A. Fifteen (15) cases of COVID-19 have been confirmed in the inmate population - two (2) at the Mississippi State Penitentiary (MSP) at Parchman, two (2) at the Winston-Choctaw County Regional Correctional Facility, six (6) at the Marion-Walshall County Regional Correctional Facility, and three (3) at the Carroll-Montgomery County Regional Correctional Facility. Two (2) cases have been reported at the East Mississippi Correctional Facility.

Q-3. What happens in the event of a confirmed case of COVID-19 in an MDOC facility?

A. The MDOC has extensive protocols in place to address scenarios when illness is present. These include immediate quarantine and treatment at facility infirmaries, designated areas or outside hospitals as necessary. Sterilization of all surfaces also is included. Inmates in close proximity to any inmate testing positive are quarantined and receive enhanced screening in addition to wearing a mask. Quarantined inmates are monitored daily for symptoms of the coronavirus.

Q-4. In addition to the positive inmate cases, how many other inmates have been tested and what is the status of those tests?

A. The MDOC has tested 39 other inmates. Thirty-five (35) tests show negative results. Four (4) tests results are pending.

Q-5. How many MDOC employees have tested positive?

A. The department has eight (8) employees to test positive for COVID-19.

Q-6. How many other employees have been tested and what is the status of those tests?

A. Forty (41) other employees have tested. Thirty-nine (39) tests show negative results. Two (2) test results are pending.

Q-7. When does MDOC test inmates for COVID-19?

A. The criteria for testing inmates are the same as for the general public. Testing priorities include having a fever of 100.4 or above and symptoms of an acute respiratory illness (cough or difficulty breathing). Inmates with fever and respiratory illness are tested for influenza. If the influenza tests are negative, then the inmate is tested for COVID-19. The inmate patient will remain isolated in the infirmary until the test result is received.

Q-8. Are inmates required to pay medical co-pay during the COVID-19 pandemic?

A. No. Co-pay for any inmate sick call related to influenza or COVID-19 is waived.



Q-9. How long will the restrictions on visitation for family, friends, and volunteers continue?

A. A date for lifting restrictions has not been determined. Resuming visitation is based on current updates of the COVID-19 impact.

Q-10. If I usually travel from out of state to Mississippi to visit an inmate, how can I find out the status of the visitation suspension before I leave?

A. Call the facility first. Telephone numbers are listed on the MDOC website (www.mdcc.ms.gov) or contact the Office of Communications at MDOCOfficeofCommunications@mdcc.state.ms.us

Q-11. Are inmates allowed to meet with their attorneys?

A. Yes. All legal visits are permitted. The legal visit areas are sanitized after each visit.

Q-12. How can family and friends maintain contact with their incarcerated loved ones?

A. Telephone calls through the inmate phone system will continue uninterrupted. The United States mail also is a good way to communicate with inmates.

Q-13. In addition to masks, gloves, and hand sanitizers being provided, what other steps have been taken to protect staff and inmates from potential exposure to the coronavirus?

A. Additional cleaning is occurring. Fire and safety staff are ensuring that additional chemicals are available in the housing units. Inmates are receiving antibacterial soap. The MDOC is recommending staff and inmates follow the health guidelines from the Centers for Disease Control (CDC) and Prevention. Social, distance, and hygiene protocols are being followed as well as the avoidance of unnecessary groups or meetings of ten (10) or more.

Q-14. Can inmates travel on approved leave, such as to funerals or wakes?

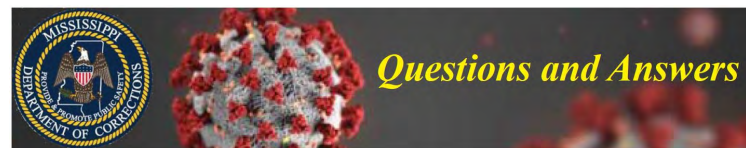
A. No. Movement remains suspended.

Q-15. Are prisons on lockdown because of COVID-19?

A. No. Prisons are not on lockdown.

Q-16. What activities can inmates participate in during this time? Will activities, including educational and religious programs, continue?

A. Programming remains suspended. However, inmates are free to participate in recreational activities while practicing social distancing.



Q-17. If an inmate is scheduled to be released, will the release occur?

A. Yes. All scheduled releases will occur as planned.

Q-18. Will inmates be considered for early release because of the coronavirus pandemic?

A. No. Inmates are being released through the standard release practice.

Q-19. Are inmate transfers affected?

A. Yes. There are limited transfers of inmates between MDOC facilities unless absolutely necessary.

Q-20. Is the MDOC accepting new inmates into the system?

A. Yes, but under limited circumstances.

Q-21. Are inmates allowed to go off grounds for work assignments?

A. No. Inmate work crews remain suspended.

Q-22. Should people on community supervision, including probation/parole, continue reporting to supervising agents via email or phone?

A. Yes. The phone call will serve as their report. All calls must be made between 7 a.m. and 6 p.m. Monday through Friday. No calls will be accepted on weekends. Individuals are not required to speak with their assigned agent when they call. Individuals must provide the person answering the phone with their name, MDOC number, address, and phone number. They will be asked additional questions related to employment and other issues specifically as a result of the COVID-19 pandemic. Individuals can also email their agent or use technology portals, such as Skype and FaceTime, to communicate. Individuals will be considered non-reporting if they fail to contact the MDOC.

Community supervision also includes house arrest, earned release supervision, conditional medical release, and interstate compact, which includes movement between states.

Q-23. Is out-of-state travel permitted for individuals on supervision?

A. No. Issuance of permits remains suspended until further notice.



Q-24. What is the MDOC's current COVID-19 practice regarding individuals in the Interstate Compact program, which handles the transfers between the states of individuals under supervision?

A. Mississippi is only processing incoming transfers that are resident, resident family, and military. Approvals are only for probationers living in the receiving state at the time of sentencing and those with military affiliation.

For outgoing cases, go to interstatecompact.org for a list of state restrictions to see if an offender will be able to transfer to a particular state. The list changes frequently so you should check it often for the most current information.

For current information regarding the coronavirus, visit the following websites:

www.coronavirus.gov

www.cdc.gov/COVID19

<https://msdh.ms.gov>

**The Mississippi Coronavirus Hotline is available 8 a.m. until 5 p.m. Monday-Friday
Call **877-978-6453****

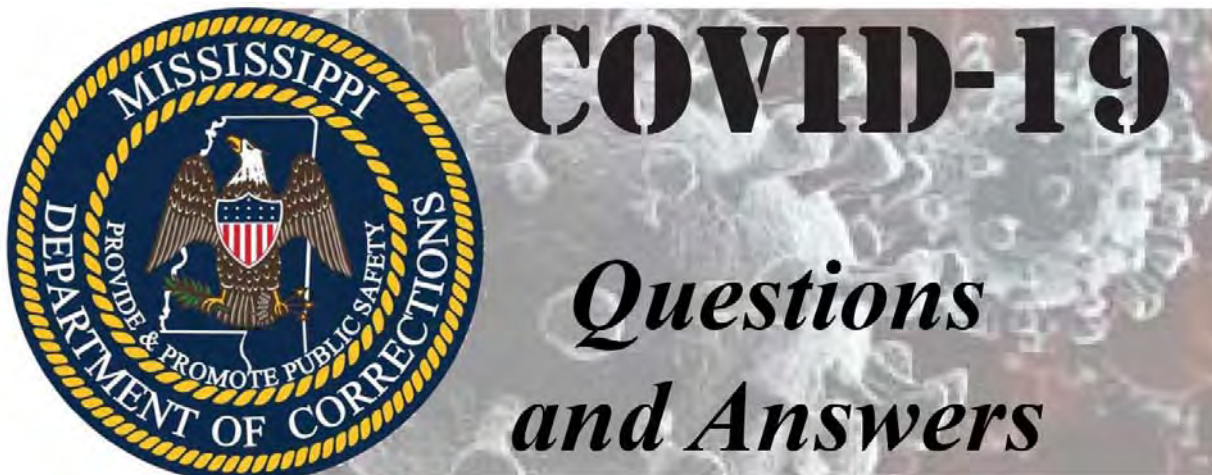
COVID-19 Confirmed Inmate Cases
MISSISSIPPI DEPARTMENT OF CORRECTIONS

Facility	Positive
STATE INSTITUTIONS	
Mississippi State Penitentiary, Parchman	2
Central Mississippi Correctional Institution, Pearl	0
South Mississippi Correctional Institution, Leakesville	0
PRIVATE PRISONS	
East Mississippi Correctional Facility, Meridian	2
Marshall County Correctional Facility, Holly Springs	0
Wilkinson County Correctional Facility, Woodville	0
REGIONAL CORRECTIONAL FACILITIES	
Alcorn County Correctional Facility	0
Bolivar County Correctional Facility	0
Carroll-Montgomery County Correctional Facility	3
Chickasaw County Correctional Facility	0
George County Correctional Facility	0
Holmes-Humphreys County Correctional Facility	0
Issaquena County Correctional Facility	0
Jefferson-Franklin County Correctional Facility	0
Kemper-Neshoba County Correctional Facility	0
Leake County Correctional Facility	0
Marion-Walthall County Correctional Facility	6
Stone County Correctional Facility	0
Washington County Correctional Facility	0
Winston-Choctaw County Correctional Facility	2
Yazoo County Correctional Facility	0
Total	15

Last update: May 15, 2020; 5 p.m.

For more information about COVID-19 in the MDOC, visit the Information and Updates page at <https://www.mdoc.ms.gov/Pages/COVID-19-Information-and-Updates.aspx>

APPENDIX 3



**Answers to some of the most frequently asked questions:
Last Update: May 21, 5 p.m.**

Q-1. What is the Mississippi Department of Corrections doing to ensure the well-being of staff and inmates?

A. The MDOC has provided masks to all inmates and correctional staff. Gloves and additional soap are provided. Hand sanitizer stations are installed in strategic locations for both staff and inmates' use. Fire and safety personnel are sanitizing all areas. Information regarding frequent hand washing, cough hygiene, and social distancing has been distributed to staff and inmates. Signs are posted in facilities. Staff and inmates are recommended to follow health guidelines from the Centers for Disease Control (CDC) and Prevention.

Inmates can access medical staff using the sick call system. A face-to-face triage is completed within 24 hours of submission of the sick call request. Medical staff are seeing inmates with acute respiratory symptoms in a timely manner. Symptomatic inmates with fever are tested according to Mississippi State Department of Health and CDC guidelines. They will be quarantined, according to MSDH and CDC guidelines. Affected patients will receive treatment and may be transferred to a community hospital, if symptoms become severe.

Security staff and non-security staff are screened daily for elevated temperature. Staff found to have a fever (temperature of 100.4 or above) will not be allowed to report to work that day and will be advised to contact their doctor's office. Staff members who are feeling ill prior to reporting for duty are urged to stay home and see their physician, if needed. A screening tool questionnaire has also been implemented for staff arriving at a correctional facility. The questions include asking about recent travel from an affected country and possible exposure to someone who has suspected or confirmed COVID-19 disease.



Q-2. How many confirmed cases are in the inmate population?

A. Twenty-one (21) cases of COVID-19 have been confirmed in the inmate population – two (2) at the Central Mississippi Correctional Facility, two (2) at the Mississippi State Penitentiary (MSP) at Parchman, three (3) at the East Mississippi Correctional Facility, three (3) at the Carroll-Montgomery County Regional Correctional Facility, nine (9) at the Marion-Walthall County Regional Correctional Facility, and two (2) at the Winston-Choctaw County Regional Correctional Facility.

Q-3. What happens in the event of a confirmed case of COVID-19 in an MDOC facility?

A. The MDOC has extensive protocols in place to address scenarios when illness is present. These include immediate quarantine and treatment at facility infirmaries, designated areas or outside hospitals as necessary. Sterilization of all surfaces also is included. Inmates in close proximity to any inmate testing positive are quarantined and receive enhanced screening in addition to wearing a mask. Quarantined inmates are monitored daily for symptoms of the coronavirus.

Q-4. In addition to the positive inmate cases, how many other inmates have been tested and what is the status of those tests?

A. The MDOC has tested 44 other inmates. Thirty-eight (38) tests show negative results and six (6) test results are pending.

Q-5. How many MDOC employees have tested positive?

A. The department has ten (10) employees to test positive for COVID-19.

Q-6. How many other employees have been tested and what is the status of those tests?

A. Fifty-two (52) other employees have tested. Forty-three (43) tests showed negative results. Nine (9) test results are pending.

Q-7. When does MDOC test inmates for COVID-19?

A. The criteria for testing inmates are the same as for the general public. Testing priorities include having a fever of 100.4 or above and symptoms of an acute respiratory illness (cough or difficulty breathing). Inmates with fever and respiratory illness are tested for influenza. If the influenza tests are negative, then the inmate is tested for COVID-19. The inmate patient will remain isolated in the infirmary until the test result is received.

Q-8. Are inmates required to pay medical co-pay during the COVID-19 pandemic?

A. No. Co-pay for any inmate sick call related to influenza or COVID-19 is waived.



Q-9. How long will the restrictions on visitation for family, friends, and volunteers continue?

A. A date for lifting restrictions has not been determined. Resuming visitation is based on current updates of the COVID-19 impact.

Q-10. If I usually travel from out of state to Mississippi to visit an inmate, how can I find out the status of the visitation suspension before I leave?

A. Call the facility first. Telephone numbers are listed on the MDOC website (www.mdod.ms.gov) or contact the Office of Communications at MDOCOfficeofCommunications@mdoc.state.ms.us

Q-11. Are inmates allowed to meet with their attorneys?

A. Yes. All legal visits are permitted. The legal visit areas are sanitized after each visit.

Q-12. How can family and friends maintain contact with their incarcerated loved ones?

A. Telephone calls through the inmate phone system will continue uninterrupted. The United States mail also is a good way to communicate with inmates.

Q-13. In addition to masks, gloves, and hand sanitizers being provided, what other steps have been taken to protect staff and inmates from potential exposure to the coronavirus?

A. Additional cleaning is occurring. Fire and safety staff are ensuring that additional chemicals are available in the housing units. Inmates are receiving antibacterial soap. The MDOC is recommending staff and inmates follow the health guidelines from the Centers for Disease Control (CDC) and Prevention. Social, distance, and hygiene protocols are being followed as well as the avoidance of unnecessary groups or meetings of ten (10) or more.

Q-14. Can inmates travel on approved leave, such as to funerals or wakes?

A. No. Movement remains suspended.

Q-15. Are prisons on lockdown because of COVID-19?

A. No. Prisons are not on lockdown.

Q-16. What activities can inmates participate in during this time? Will activities, including educational and religious programs, continue?

A. Programming remains suspended. However, inmates are free to participate in recreational activities while practicing social distancing.



Q-17. If an inmate is scheduled to be released, will the release occur?

A. Yes. All scheduled releases will occur as planned.

Q-18. Will inmates be considered for early release because of the coronavirus pandemic?

A. No. Inmates are being released through the standard release practice.

Q-19. Are inmate transfers or movement from county jails affected?

A. Yes. There are limited transfers of inmates between MDOC facilities and from county jails, unless absolutely necessary.

Q-20. Are inmates allowed to go off grounds for work assignments?

A. No. Inmate work crews remain suspended.

Q-21. Should people on community supervision, including probation/parole, continue reporting to supervising agents via email or phone?

A. Yes. The phone call will serve as their report. All calls must be made between 7 a.m. and 6 p.m. Monday through Friday. No calls will be accepted on weekends. Individuals are not required to speak with their assigned agent when they call. Individuals must provide the person answering the phone with their name, MDOC number, address, and phone number. They will be asked additional questions related to employment and other issues specifically as a result of the COVID-19 pandemic. Individuals can also email their agent or use technology portals, such as Skype and FaceTime, to communicate. Individuals will be considered non-reporting if they fail to contact the MDOC.

Community supervision also includes house arrest, earned release supervision, conditional medical release, and interstate compact, which includes movement between states.

Q-22. Is out-of-state travel permitted for individuals on supervision?

A. No. Issuance of permits remains suspended until further notice.

Q-23. What is the MDOC's current COVID-19 practice regarding individuals in the Interstate Compact program, which handles the transfers between the states of individuals under supervision?

A. Mississippi is only processing incoming transfers that are resident, resident family, and military. Approvals are only for probationers living in the receiving state at the time of sentencing and those with military affiliation.

For outgoing cases, go to [interstatecompact.org](https://www.interstatecompact.org) for a list of state restrictions to see if an offender will be able to transfer to a particular state. The list changes frequently so you should check it often for the most current information.



For current information regarding the coronavirus, visit the following websites:

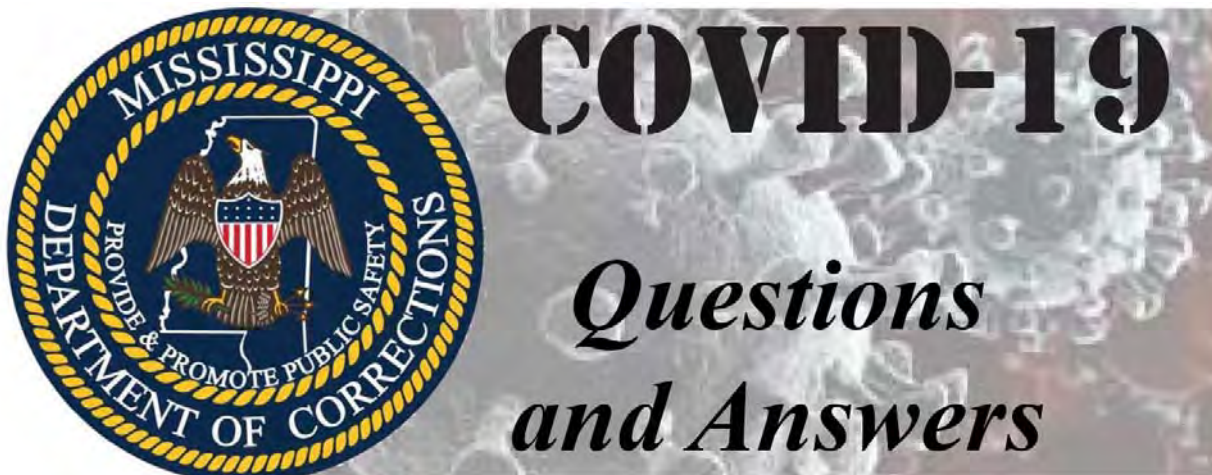
www.coronavirus.gov

www.cdc.gov/COVID19

<https://msdh.ms.gov>

**The Mississippi Coronavirus Hotline is available 8 a.m. until 5 p.m. Monday-Friday
Call **877-978-6453****

APPENDIX 4



**Answers to some of the most frequently asked questions:
Last Update: May 22, 5 p.m.**

Q-1. What is the Mississippi Department of Corrections doing to ensure the well-being of staff and inmates?

A. The MDOC has provided masks to all inmates and correctional staff. Gloves and additional soap are provided. Hand sanitizer stations are installed in strategic locations for both staff and inmates' use. Fire and safety personnel are sanitizing all areas. Information regarding frequent hand washing, cough hygiene, and social distancing has been distributed to staff and inmates. Signs are posted in facilities. Staff and inmates are recommended to follow health guidelines from the Centers for Disease Control (CDC) and Prevention.

Inmates can access medical staff using the sick call system. A face-to-face triage is completed within 24 hours of submission of the sick call request. Medical staff are seeing inmates with acute respiratory symptoms in a timely manner. Symptomatic inmates with fever are tested according to Mississippi State Department of Health and CDC guidelines. They will be quarantined, according to MSDH and CDC guidelines. Affected patients will receive treatment and may be transferred to a community hospital, if symptoms become severe.

Security staff and non-security staff are screened daily for elevated temperature. Staff found to have a fever (temperature of 100.4 or above) will not be allowed to report to work that day and will be advised to contact their doctor's office. Staff members who are feeling ill prior to reporting for duty are urged to stay home and see their physician, if needed. A screening tool questionnaire has also been implemented for staff arriving at a correctional facility. The questions include asking about recent travel from an affected country and possible exposure to someone who has suspected or confirmed COVID-19 disease.



Q-2. How many confirmed cases are in the inmate population?

A. Twenty-three (23) cases of COVID-19 have been confirmed in the inmate population – three (3) at the Central Mississippi Correctional Facility, two (2) at the Mississippi State Penitentiary (MSP) at Parchman, three (3) at the East Mississippi Correctional Facility, three (3) at the Carroll-Montgomery County Regional Correctional Facility, one (1) at Delta Correctional Facility, nine (9) at the Marion-Walthall County Regional Correctional Facility, and two (2) at the Winston-Choctaw County Regional Correctional Facility.

Q-3. What happens in the event of a confirmed case of COVID-19 in an MDOC facility?

A. The MDOC has extensive protocols in place to address scenarios when illness is present. These include immediate quarantine and treatment at facility infirmaries, designated areas or outside hospitals as necessary. Sterilization of all surfaces also is included. Inmates in close proximity to any inmate testing positive are quarantined and receive enhanced screening in addition to wearing a mask. Quarantined inmates are monitored daily for symptoms of the coronavirus.

Q-4. In addition to the positive inmate cases, how many other inmates have been tested and what is the status of those tests?

A. The MDOC has tested forty-five (45) other inmates. Thirty-eight (40) tests show negative results and five (5) test results are pending.

Q-5. How many MDOC employees have tested positive?

A. The department has eleven (11) employees to test positive for COVID-19.

Q-6. How many other employees have been tested and what is the status of those tests?

A. Sixty-one (61) other employees have tested. Forty-three (43) tests showed negative results. Eighteen (18) test results are pending.

Q-7. When does MDOC test inmates for COVID-19?

A. The criteria for testing inmates are the same as for the general public. Testing priorities include having a fever of 100.4 or above and symptoms of an acute respiratory illness (cough or difficulty breathing). Inmates with fever and respiratory illness are tested for influenza. If the influenza tests are negative, then the inmate is tested for COVID-19. The inmate patient will remain isolated in the infirmary until the test result is received.

Q-8. Are inmates required to pay medical co-pay during the COVID-19 pandemic?

A. No. Co-pay for any inmate sick call related to influenza or COVID-19 is waived.



Q-9. How long will the restrictions on visitation for family, friends, and volunteers continue?

A. A date for lifting restrictions has not been determined. Resuming visitation is based on current updates of the COVID-19 impact.

Q-10. If I usually travel from out of state to Mississippi to visit an inmate, how can I find out the status of the visitation suspension before I leave?

A. Call the facility first. Telephone numbers are listed on the MDOC website (www.mdocr.ms.gov) or contact the Office of Communications at MDOCOfficeofCommunications@mdocr.state.ms.us

Q-11. Are inmates allowed to meet with their attorneys?

A. Yes. All legal visits are permitted. The legal visit areas are sanitized after each visit.

Q-12. How can family and friends maintain contact with their incarcerated loved ones?

A. Telephone calls through the inmate phone system will continue uninterrupted. The United States mail also is a good way to communicate with inmates.

Q-13. In addition to masks, gloves, and hand sanitizers being provided, what other steps have been taken to protect staff and inmates from potential exposure to the coronavirus?

A. Additional cleaning is occurring. Fire and safety staff are ensuring that additional chemicals are available in the housing units. Inmates are receiving antibacterial soap. The MDOC is recommending staff and inmates follow the health guidelines from the Centers for Disease Control (CDC) and Prevention. Social, distance, and hygiene protocols are being followed as well as the avoidance of unnecessary groups or meetings of ten (10) or more.

Q-14. Can inmates travel on approved leave, such as to funerals or wakes?

A. No. Movement remains suspended.

Q-15. Are prisons on lockdown because of COVID-19?

A. No. Prisons are not on lockdown.

Q-16. What activities can inmates participate in during this time? Will activities, including educational and religious programs, continue?

A. Programming remains suspended. However, inmates are free to participate in recreational activities while practicing social distancing.



Q-17. If an inmate is scheduled to be released, will the release occur?

A. Yes. All scheduled releases will occur as planned.

Q-18. Will inmates be considered for early release because of the coronavirus pandemic?

A. No. Inmates are being released through the standard release practice.

Q-19. Are inmate transfers or movement from county jails affected?

A. Yes. There are limited transfers of inmates between MDOC facilities and from county jails, unless absolutely necessary.

Q-20. Are inmates allowed to go off grounds for work assignments?

A. No. Inmate work crews remain suspended.

Q-21. Should people on community supervision, including probation/parole, continue reporting to supervising agents via email or phone?

A. Yes. The phone call will serve as their report. All calls must be made between 7 a.m. and 6 p.m. Monday through Friday. No calls will be accepted on weekends. Individuals are not required to speak with their assigned agent when they call. Individuals must provide the person answering the phone with their name, MDOC number, address, and phone number. They will be asked additional questions related to employment and other issues specifically as a result of the COVID-19 pandemic. Individuals can also email their agent or use technology portals, such as Skype and FaceTime, to communicate. Individuals will be considered non-reporting if they fail to contact the MDOC.

Community supervision also includes house arrest, earned release supervision, conditional medical release, and interstate compact, which includes movement between states.

Q-22. Is out-of-state travel permitted for individuals on supervision?

A. No. Issuance of permits remains suspended until further notice.

Q-23. What is the MDOC's current COVID-19 practice regarding individuals in the Interstate Compact program, which handles the transfers between the states of individuals under supervision?

A. Mississippi is only processing incoming transfers that are resident, resident family, and military. Approvals are only for probationers living in the receiving state at the time of sentencing and those with military affiliation.

For outgoing cases, go to [interstatecompact.org](https://www.interstatecompact.org) for a list of state restrictions to see if an offender will be able to transfer to a particular state. The list changes frequently so you should check it often for the most current information.



For current information regarding the coronavirus, visit the following websites:

www.coronavirus.gov

www.cdc.gov/COVID19

<https://msdh.ms.gov>

**The Mississippi Coronavirus Hotline is available 8 a.m. until 5 p.m. Monday-Friday
Call **877-978-6453****

EXHIBIT 3

DECLARATION OF JAMARCUS DAVIS

I, Jamarcus Davis, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I live at South Mississippi Correctional Institution (SMCI) and have since about November 2019.
2. I am currently housed in Area 1, Unit 8. I have been on this zone for a few weeks. There are twenty-six two-person cells. I live with another person. Fifty-two men total live in my unit. Each cell has its own toilet and sink. The cells might be about eight feet by ten feet.
3. Up until a few weeks ago, I was housed in Area 2, Building A1, B-Zone. It was an open bay design that housed 100 residents. The beds were a couple feet apart at most.
4. When I lived there, about two months ago, I got very sick. I had a high fever, cold sweats, and a very bad cough. I was coughing uncontrollably. A number of other inmates told me that I was coughing in my sleep. I was coughing so much I couldn't eat. My body was aching, my head was pounding, and my joints and legs hurt especially bad.
5. I put in a sick call slip. I could basically only lay in bed. It took days to get seen. When they called me up to the infirmary, I noticed that most of the medical staff were not wearing masks. They never put a mask on me. I was coughing a lot, but I was feeling slightly better than I did when I put the sick call slip in to get seen. They checked my temperature and said I had a fever. They asked how I was feeling and I could barely talk because of all of the coughing.
6. They prescribed me cold medicine and generic Motrin and sent me back to the unit.
7. They did not test me for the flu. They did not test me for coronavirus. They did not quarantine me. I knew about the coronavirus at the time. Talk about it was everywhere. I did not ask them if I had it or anything about it. They did not mention it to me.
8. When they sent me back to the zone right after the appointment, all I could do was lay in my rack and try to sleep it off. I felt like it was killing me. I spent days there.
9. The beds in my old zone were a couple of feet apart. Whatever I had spread like wildfire in the zone. Out of 100 men, I'd estimate about 30 individuals ended up showing symptoms, maybe not as bad as me, but many people were seen at the infirmary for it.
10. I do not know anyone who went to the infirmary because of this illness who was tested for the flu or for coronavirus, and we all talked a lot about how sick we were.

There was this terrible cough going around the zone. There was the sound for days of just really bad coughing. People who did visit the infirmary for it that I know were just prescribed cold and congestion medication, and Motrin or Tylenol for the pain.

11. Whatever illness it was just spread. Nobody was ever isolated or quarantined, individually or the zone generally. They never put a mask on anyone in the zone.
12. I and others have asked MDOC and staff about prison procedures related to coronavirus. We get no response. I asked what the plan is if the virus gets into our unit, and what MDOC will do if one of us gets coronavirus. I have gotten either no answer or, most recently, one answer: that guards would stop coming to work and leave us in here alone. I have been at SMCI when not enough guards have come to work to operate the prison. Once for two months we were locked in our cells and never let out: no showers, no yard, no dayroom. We washed our bodies out of a sink for two months. It was very difficult. I am terrified that is what they will do to us if we get sick and the guards stop coming to work.
13. After the person imprisoned at Mississippi State Penitentiary at Parchman recently died from the virus, staff told us that no inmate in the Mississippi prison system has gotten coronavirus.
14. In the past couple of weeks, I have seen guards start to wear masks. However, many officers still walk around the zone without a mask or gloves. Some officers who do wear masks only wear them halfway on their face or just around their neck.
15. We are in the common areas all day and in our cells at night. The common area consists of two sections with benches and shared tables. Most of the space on the zone is made up of our living area, not the common area.
16. We are not being provided with chemicals to clean our living areas.
17. We are not being provided with chemicals daily to clean common areas. Some days, but not regularly or often, staff come on the zone to see if people are cleaning the common areas.
18. There are not enough staff to ensure that chemicals that do make it to the zone are used to clean the zone, so they often aren't. Diverted cleaning supplies are sold on the zone. It is possible to buy or trade others for these cleaning supplies, but that is not something many people can afford or want to do. Residents would clean their living spaces if given the opportunity; people are afraid of the coronavirus. There are never enough chemicals to go around to daily sanitize.
19. Sometimes the people cleaning are wearing masks. Sometimes they are wearing gloves, but typically not.
20. I have never witnessed staff cleaning equipment they share with other staff.

21. In the past week or two, we were provided with a mask and a pair of gloves. We were not given any instructions whatsoever regarding when or where to wear them. As a result, out of 52 residents on the zone, one or two at any given time might be wearing a mask.
22. If you are fortunate enough to have commissary, you buy soap off of commissary. If you are not, which is the case for most residents, you use the state soap. We get two bars of soap a month. I run out of soap all of the time, every month at least once or twice. I have to trade or barter to get someone else's soap if they have extra.
23. I have asked for more soap when I run out, and staff have refused. Staff say we have to wait until the next time the state issues it. I sometimes avoid washing my hands to try and stretch the soap. For example, I prefer to shower every day. However, some days I want to shower but know that if I do, I won't have enough soap to wash my hands through the rest of the week. I have to choose one or the other.
24. We also have to use our ration of state soap to wash our clothing.
25. We have no access to disposable paper towels or hand drying machines.
26. We get one roll of tissue every other week. It is an all-purpose role: for using the bathroom, napkins, Kleenex, everything. We run out of toilet paper a lot. I have frequently run out of toilet paper.
27. Nobody has ever told us to stand six feet apart or try to. Not for pill call, not for day room, not for anything. It would be physically impossible for us to do that.
28. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or respiratory symptoms.
29. I have not heard or read of any process by which to get seen sooner by medical staff if we have symptoms of coronavirus.
30. I have not been offered the flu vaccine and have not had one.
31. I am under the care of a physician for anxiety or depression. I am prescribed medication to treat symptoms related to my mental health. My symptoms have gotten worse because of my worries about the coronavirus and MDOC not doing enough to protect us. I have nightmares about it often.
32. Because coronavirus is in many prisons, I fear for my safety, health, and life.
33. I have wanted to file an ARP about the need for MDOC to do more to protect us from coronavirus, but you can only get ARP forms from the tower officer. I asked the tower officer for an ARP form a couple of weeks ago, and the officer would not provide one. I asked again, and I did get one. I asked the tower officer if there was such a thing as an emergency ARP so I could file one about the lack of coronavirus precautions. She

said there wasn't such a thing. I tried to submit a regular ARP. I gave the completed ARP form to the tower officer. She didn't know if it went into the regular mail or the ILAP box. She called ILAP, who told her it was not mail. By process of elimination, I had to assume I was to put it in the ILAP box. She let me go out of the zone and put it in there. I don't know if it reached its destination. I have been informed that ILAP is not providing ILAP services unless someone has written proof that they have a deadline.

34. In the past when I have submitted an ARP, it takes months to hear a response. I have never had an ARP granted that I recall. It is very rare that one is. It is also commonplace to submit an ARP and not receive any response. That has happened to me. It's a dead end process. A lot of people try but just lose hope and give up on using the process. Getting any resolution one way or the other is rare, let alone getting one in your favor.

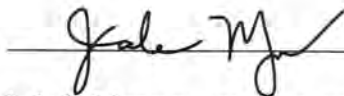
35. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 6, 2020

Signature: 
Paloma Wu signing for Jamarcus Davis of Greene County, Mississippi

Witness Signature:

A handwritten signature in black ink, appearing to read "Jade Morgan", written over a horizontal line.

Dated: May 6, 2020

I, Jade Morgan, am an attorney barred in Mississippi.
On May 6, 2020, I joined a phone call with Declarant Jamarcus Davis and Attorney Paloma Wu. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the attorney to execute it by signing on the Declarant's behalf.

EXHIBIT 4

DECLARATION OF ROGER EWING

I, Roger Ewing, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at Central Mississippi Correctional Facility (CMCF). I am 68 years old.
2. I am currently housed in Unit 720, in Building B2, C-Zone. My zone is set up as an open bay, meaning it is a large box with racks of bunks in which approximately 100 individuals live. Our building is composed of two zones, so it contains approximately 200 individuals total. There is one tower situated between and over both of the building's two zones. There are a number of buildings like ours at CMCF.
3. CMCF is very understaffed. There routinely is no officer present who can respond to the needs of the 100 men in our zone and the 200 men in our building.
4. Multiple staff are supposed to be on our zone at all times. Back in the day, many years ago, in a zone like mine there would be three officers in the tower, called the tower officers, and another officer walking around the zone. These days, sometimes there are zero officers—none in the tower and none on the zone—for many hours at a time—even for an entire shift, which is twelve hours.
5. When staff are on duty, there is usually only one guard in the tower to oversee all 200 individuals who live in the building—with no additional officers on the zone. Sometimes, particularly on the weekends, we appear to be sharing our single tower officer with other buildings: he or she runs to our tower for a time then leaves all 200 individuals without any supervision to cover another building of 200 men for a time. That is one guard per 400 residents.
6. People have died in here because no guard is present to respond to their medical emergency and they can't get out the locked door to go to medical.
7. I myself have severe asthma attacks that I can die from. Medical staff have directed me to come straight to the clinic as soon as I feel one coming on. I have tried to do as medical staff have directed and have failed because no tower officer—no officer at all—was watching the 400 of us. Those times, I have had to ride the asthma attack out, barely able to breathe. I've been lucky so far. But it only takes one time. The next time I need to go to medical and there is no officer here, I may end up like those other people who needed medical attention, no officer was here to respond, and they died.
8. I suffer from chronic asthma and the beginning stages of emphysema. I have had multiple strokes and use a wheelchair because I have lost my equilibrium: if I stand up, I fall. I have had multiple bouts of cancer and have had operations every couple of years for the past few years to remove it. I have bad kidneys. Every couple of years, I have to get kidney stones removed. I also get nerve pain because of the bad falls I've had due

to my stroke and because I had boiling water thrown on me at Parchman, which burned nearly half of my body.

9. I am currently under the care of a physician for these conditions and take prescription medication. To treat my lung disease, I am prescribed a maintenance inhaler and an emergency inhaler.
10. My chronic medical conditions make it difficult for me to breath normally and substantially impair my ability to walk, work, and sleep. If I stand up out of my wheelchair, I generally fall and sometimes fall and hit my head. Because of the nerve pain, I cannot sleep more than a few hours at night, and I sleep that much because I am exhausted.
11. Because coronavirus is in many prisons and I suffer from underlying medical conditions, I fear for my safety, health, and life.
12. Common areas in the zone include the day room. That is the area that is in front of the zone that contains the TVs, the tables where some people eat at, our two microwaves, the bathrooms, the showers, and the sinks.
13. These common areas are supposed to be cleaned by residents assigned to do it, but that is not happening. There is no staff supervision to ensure the people assigned to clean are doing the cleaning. There are not enough staff to supervise or enforce cleaning. I am in a wheelchair and cannot walk without falling, but I clean all of these common areas as best I can every night. I'm about the only one that does it, besides one resident who mops every couple of days, as I cannot mop, and one resident who sprays certain things sometimes but does not clean.
14. I am not assigned to do this cleaning work but the bottle of chemical meant to be used for these purposes is given to me because nobody else is doing it. There are not enough cleaning supplies to clean the common areas nightly.
15. We were just provided with masks the week of April 20, 2020. The day after we received the masks, the staff member over our building announced to our zone that we are forbidden to wear the masks in the building because the guards cannot identify men on camera if they are wearing a mask. She said it was a security concern. She ordered that we only wear our masks when we are outside. People on my zone are now not wearing masks because they do not want to get an RVR—a Rules Violation Report—for doing so.
16. There are no cleaning supplies available to clean around the racks and other living spaces. We have asked but they will not give us more. We spend most of our time in these spaces and they take up the vast majority of the total area of the zone.
17. The state provides us with a bar of state soap every week, but it does not last a week if you wash your hands regularly.

18. The state soap the prison provides irritates many peoples' skin. Many people have told me that they do not use any soap because of this. I am in the bathroom often doing cleaning. On average, about three-quarters of men who use the bathroom that I see do not wash their hands with soap. I have asked many of them why they don't. They have said the state soap is abrasive and irritates their skin.
19. The prison gave us a bar of Dial soap because of coronavirus and about a month later provided another bar of it. The bar of Dial soap lasts not more than about two weeks if you are washing your hands regularly.
20. There is no soap available in the bathroom—you have to bring your personal bar of soap in and out if you want to use it.
21. We do not have disposable paper towels for hand washing or hand drying machines. They used to have paper towel dispensers in the bathrooms a long time ago but they took them out.
22. We do not have face tissues. We get one roll of toilet tissue every week to use for both our bathroom and facial tissue needs. If you are coughing or sneezing and you use your toilet tissue, you have less toilet tissue for the week for using the bathroom. I have run out of toilet tissue before.
23. We do not have hand sanitizer.
24. A flyer was posted up on our zone window about coronavirus precautions. It was on the bulletin board for about a day before it was torn down; it was never replaced. It was only in English.
25. No additional information about coronavirus or how to reduce risk around it has been communicated.
26. When we are in the common area, on our racks, or anywhere else on the zone, we are not six feet apart. It is impossible to stay six feet apart because of how many people live on the zone and how overcrowded it is. No one has told us to try to stay six feet apart.
27. Typically, if I fill out a sick call slip and submit it, it takes a few days to over a week to get seen by medical staff. We have not been told of any procedure for getting seen sooner if we have symptoms of coronavirus.
28. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or respiratory symptoms. Some people would not want to go to medical to be charged six dollars for that sick call form.
29. I would like to submit an ARP, or grievance, about the lack of steps MDOC has taken to protect us from the coronavirus. However, MDOC's ARP system only allows individuals in prison to have a single ARP about a single issue in the exhaustion pipeline at a time. It takes months to exhaust one ARP, and I have previously submitted an ARP

which is pending exhaustion. I believe the lack of steps taken pose an imminent threat to my life and health and others' life and health. However, I cannot for a number of months begin to exhaust an ARP on the lack of coronavirus precautions in place.

30. Therefore, no process is available to me that would help me or others not get sick or die from a preventable coronavirus outbreak in the coming months.

31. I have heard on the news about the virus running rampant in the Ohio prison system, and I am terrified that could happen here in Mississippi. I am afraid that if I am exposed to coronavirus, I would become very ill extremely quickly because of my medical conditions, and I would not be isolated for others' safety or be able to get help in time to survive.

32. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 6, 2020

Signature:



Paloma Wu signing for Roger Ewing of Rankin County, Mississippi

Witness Signature:



Dated: May 6, 2020

I, Matthew Layton, am an attorney barred in Mississippi.
(On May 6, 2020), I joined a phone call with the Declarant and the above-listed attorney. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on his behalf.

Re: Roger Ewing
Declaration

EXHIBIT 5

DECLARATION OF DANIEL HATTEN

I, Daniel Hatten, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at Central Mississippi Correctional Facility (CMCF). I have been housed here since the beginning of March of 2020. Previously, I was housed at Mississippi State Prison at Parchman.
2. CMCF is very understaffed. Most of the individual staff members I have encountered at CMCF, including the contracted guards from the private company, Advert, try hard to do what they can with what they have to take care of us. I appreciate that a lot, especially since where I was housed before, I never felt safe.
3. I am currently housed in R&C, Zone D, and have been since I came here. I live in a two-person cell and do not currently have a cellmate. On my zone, there are twenty two-person cells that can hold a total of forty people. There are currently a little less than thirty people on the zone. Each cell has its own toilet and sink. On my zone, there are two showers. Every section has two zones, for a total of eighty men per section.
4. I suffer from high blood pressure and am awaiting surgery on the eye I was stabbed in back in February of this year, which improperly healed. I was diagnosed with high blood pressure here at CMCF.
5. I am under the care of a physician for my high blood pressure and take prescription medication to treat it and ulcerated hemorrhoids.
6. My high blood pressure gives me tension headaches. At times I cannot do anything at all because of these. All I can do is lay down and be still. These headaches are frequent, mostly early in the morning. I can tell when my blood pressure is elevated because of how it makes me feel. I see the doctor about monthly for my blood pressure. My injured eye is painful, has limited movement, and makes me see double.
7. My high blood pressure has kept me from moving around for part of the day like I want to.
8. Because coronavirus is in many prisons and I suffer from underlying medical conditions, I fear for my safety, health, and life.
9. The common areas, like the dayroom and the showers, are cleaned once or twice a day by inmates on the zone. We spend about four hours per day in the common area. If meals come during dayroom hours, we eat in the dayroom. Imprisoned people have a couple of times sprayed chemicals in the common areas and in the cells. We were told a couple of weeks ago this would not be happening anymore because the prison had run out of the disinfectant. These workers had no gloves when they cleaned. When we are in the dayroom having dayroom call or eating, we do not sit with extra space between us, and we do not sit six feet apart. No one has told us to.

10. We are not being provided with chemicals to clean our cells. Some people want so much to keep their spaces clean, they barter food or personal property for access to cleaning supplies. This kind of bartering is not possible for many people.
11. I do not have enough soap to wash my hands regularly and shower. To make the soap we get stretch, I avoid washing my hands sometimes to preserve my soap. Sometimes I just use water. The state soap the prison provides is what I believe to be lye soap. It irritates my skin so much that I have been breaking out with rashes from it. I'm prescribed lotion to help with the irritation of my skin from it. I sometimes avoid using the soap because it irritates my skin. My skin flakes, itches, and give me little rashes, black dots, where my hair grows in. We get a bar every week, but it does not last a week. It is smaller than a hotel bar of soap. The prison gave us Dial soap because of coronavirus about a month ago. Mine was used up two weeks before the arrival of another bar of Dial soap a few days ago.
12. We do not have disposable paper towels for hand washing or hand drying machines. We do not have hand sanitizer. We do not have face tissues. We get one roll of toilet tissue every week. If you are coughing or sneezing or sick and you use your toilet tissue, you have less toilet tissue for the week for using the bathroom. I have run out of toilet tissue before. People also try to trade or barter for toilet tissue because people run out of it so frequently.
13. About six or seven months ago, I noticed there was a flyer posted on the zone bulletin board saying that flu vaccines were being provided to people in chronic care. It said that if vaccines were left over, they would offer it to non-chronic care patients. Interested people could sign up on a sign-in sheet that was under the flyer. I did not put my name down.
14. A flyer is posted up on our zone window about coronavirus precautions. It is only in English. No additional information about coronavirus or how to reduce risk around it has been communicated.
15. On or around April 20, 2020, all of the residents on my zone received masks. They appear to be a single layer of fabric that may be a bedsheet. A few of the residents wear the masks. We were not told to. The guards in my zone also have masks, but they are not generally wearing them. About less than half do.
16. When the nurses come for pill call, nobody lines up six feet apart. Nobody has told us to.
17. Typically, if I fill out a sick call slip and submit it, it takes a few days to get called up. In my zone, we were told that if we had symptoms of coronavirus, we could skip the sick call process and instead tell the tower officer, who was then supposed to notify medical.
18. I have not heard or read anything about MDOC waiving the six-dollar fee for medical

visits that are related to coronavirus or respiratory symptoms. Some people would not want to go to medical because of the six dollar sick call charge.

19. Multiple staff are supposed to be on our zone at all times. However, they are short of staff, and there is sometimes one staff member only, and in the tower. When that happens, we don't get to come out of our cells for any dayroom time. Sometimes at night, the staffing is worse, and we do not have an officer in the tower. There is sometimes no officer in the tower or anywhere on the zone for four to six hours at a time. This is dangerous because if someone suddenly comes down with coronavirus symptoms, they should be isolated and treated right away for their own safety and so they won't transmit it to others.
20. I have submitted an ARP, or grievance, about needing more protection from the coronavirus, including requesting adequate soap and disinfectant. It takes about 45 days to hear back for the first step on an ARP, and there is a second step and waiting period after that before you can exhaust.
21. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: April 30, 2020

Signature:



Paloma Wu signing for Daniel Hatten of Rankin County, Mississippi

Witness Signature:



Dated: April 30, 2020

I, Matthew Lawrence, am an attorney barred in Mississippi.

On April 30, 2020, I joined a phone call with the Declarant and the above-listed attorney. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on his behalf.

EXHIBIT 6

DECLARATION OF BOB HENDERSON

I, Bob Henderson, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at South Mississippi Correctional Institution (SMCI). I have been housed here for about 4 years off and on.
2. I am currently housed in Building B1, B-Zone, and I have been for about 9 months. My zone is open bay, which means it is a large room with 100 men who sleep in double bunks. My zone is one of two zones in our building, so our building houses approximately 200 individuals. There are 8 buildings like ours at SMCI.
3. SMCI is very understaffed. Multiple staff are supposed to be on our zone at all times. However, there are usually no staff members on the zone and only one in the tower. The tower officer watches over the 200 individuals in our building at the same time. Sometimes for an hour or two, there is no tower officer, so no officer is available to respond to any needs that arise from the individuals in our building. This is because the tower officer has been there so long, they get tired and want to go home. The same officer will be in the tower for 12 or 18 hours or sometimes more than 24 hours.
4. This is dangerous because if a prisoner has a problem, there is no one to help.
5. I believe staff members are supposed to come onto the zones to conduct a count of imprisoned people every hour or every other hour to ensure our presence and safety, but staff typically only conduct counts every other day, sometimes once per week.
6. I suffer from a disease called neurofibromatosis. I was diagnosed with it when I was born. I have been treated in the past with medication for depression.
7. I am currently under the care of a physician for my neurofibromatosis. To treat my neurofibromatosis, I am supposed to receive MRIs and any necessary follow-up surgical removal of tumors found growing in dangerous locations. I have not been receiving this treatment even though I have requested it several times. I saw the doctor at SMCI about my neurofibromatosis, and he gave me a medication that was not designed to treat the disease.
8. Neurofibromatosis, which my sister and I were both born with, causes tumors to grow rampantly inside the body, on your spine, nervous system, and outside your body. It causes high blood pressure and altered vision. It throws you off balance sometimes when you walk. It causes problems with white blood cells and other medical issues.
9. My untreated neurofibromatosis makes me weak, unable to walk or stand for a substantial amount of time, and make my balance very bad. I am so off balance, sometimes I wake up holding the walls. Sometimes when I walk, my body feels like it is fixing to give out. I have to hold onto something to catch myself. This usually happens when I walk far or stand up for more than a couple of minutes at a time. I

have to stay sitting as much as possible. I sleep much more than a person usually needs to because I am unwell. I have repeatedly asked, unsuccessfully, for an MRI to find out where the tumors are growing because I am supposed to get an MRI annually or if I have dizziness or changes in my ability to walk or balance. which I have had and have told the doctor about.

10. Because coronavirus is in many prisons and I suffer from underlying medical conditions, I fear for my safety, health, and life.
11. For the 100 people who live in this zone, the bathroom area includes five toilets, four urinals, and five sinks that function. Other common areas include a TV area, 6 benches and 6 tables (3 and 3 on each side of the zone). We spend a lot of time per day in and around these common areas. In these areas, we watch TV, play chess and checkers. We also eat in the common areas on the zone. We haven't been to the cafeteria in a long time. We have been eating all three meals a day on the zone.
12. These common areas are being cleaned by incarcerated individuals who live on the zone. This cleaning is not enforced by MDOC. There are not enough staff to see that something like cleaning gets done. We do it on our own, and we try to clean once in the morning and once at night.
13. We do not get enough cleaning supplies from MDOC to clean all of the common areas. They have started bringing chemicals around in the morning, but it's not enough for all of the common areas—just enough for the restroom and shower, really.
14. Workers who clean have no masks or gloves when they clean or any protective gear except for rubber boots to keep our feet dry.
15. Workers use our own rags that we make from our towels to apply the chemical to clean common areas. We wash the towels in the sink with state soap and then hang them to dry. They are never laundered.
16. The common tables we just cover with sheets. We only clean those sometimes with chemicals.
17. Area-wise, most of the space of the zone is taken up by racks. We spend much of our time in these living areas. We have no chemicals to clean our living areas.
18. The state provides us with a bar of state soap on the 1st of the month and two bars on the 14th of the month. The bar is smaller than a hotel bar of soap.
19. The only reason I have enough soap to regularly wash my hands and shower is that I have family support, so I am able to buy additional soap from commissary. Many men on my zone do not have the ability to buy additional soap from commissary and thus run out of soap.
20. The state soap the prison provides irritates my skin. My disease causes moles and

bumps on my body and the soap irritates them. I sometimes avoid using the soap because it irritates my skin.

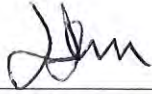
21. The prison gave us a bar of Dial soap because of coronavirus at the end of March and end of April. That soap doesn't last long because you have to shower and wash your clothes with it.
22. There is no soap available in the bathroom—you have to bring your personal bar of soap in and out if you want to use it.
23. We do not have disposable paper towels for hand washing or hand drying machines.
24. We do not have face tissues. We get one roll of toilet tissue on the 1st of the month and two rolls on the 14th of the month for our bathroom and facial tissue needs. If you are coughing or sneezing and you use your toilet tissue, you have less toilet tissue for the week for using the bathroom. I have run out of toilet tissue before. You can run out quickly and have to borrow some from a fellow inmate. This happens regularly.
25. We do not have hand sanitizer.
26. A flyer is posted up on our zone about coronavirus precautions at the beginning of March. It says to wear your mask if you leave the zone; it says if you lose your mask, you can't leave the zone. It says to wash your hands, but we don't have enough soap to do that. It is in English and Spanish.
27. No additional information about coronavirus or how to reduce risk around it has been communicated. No one has explained anything to us.
28. At the end of April, all of the imprisoned people on my zone received masks. They appear to be a single layer of fabric that is or appears to be a bedsheet.
29. In the tower guards don't wear the masks. They wear them when they are in the zone for count.
30. We are not told to wear our masks in the zone, only if we leave the zone. A few people wear masks in the zone but most do not.
31. Building D-1 got quarantined because an inmate got sick. They quarantined the building for 24 hours then opened the building back up. They did not move the inmate from the zone, just quarantined the whole building.
32. When the nurses come for pill call, nobody lines up six feet apart. No one instructed us to do so. We all pile at the door.
33. When we are in the common area eating or doing whatever, we do not sit with extra space between us, and we do not sit six feet apart. No one instructed us to do so.

34. There are no social distancing measures in the common areas, recreation, meals, group activities, housing or medical.
35. Typically, if I fill out a sick call slip and submit it, it takes 3-4 days to get seen by medical staff. To fill out a sick call slip, a tower officer has to be present. I have to ask him or her to give me a sick call slip. If they give me one, I fill it out. I may have to wait a day to be able to submit it. I would have to figure out a way to get to the sick call slip box by the cafeteria. I don't know how I would get it there. We have not been going to the cafeteria since the coronavirus came to MDOC. If I could not leave the zone to get to the cafeteria, I may have to wait until I call to hopefully give it to a member.
36. I have not heard of any expedited process to be seen by medical staff if we have symptoms of coronavirus.
37. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or respiratory symptoms.
38. Medical staff have never come onto our zone and asked us if anyone is experiencing symptoms of coronavirus.
39. I have not received a flu vaccine. They last offered it August 2019.
40. I have submitted an ARP, or grievance, about MDOC not adequately protecting us from coronavirus and not providing enough staff to help us if we have coronavirus-related medical needs.
41. To submit a grievance, or an ARP, a guard has to be in the tower. Then you must ask the guard in the tower for an ARP form. You must also get an ILAP form from the tower officer. You have to fill out an ILAP form requesting that your ARP form get picked up. You have to fill out your ILAP form request and give it on Sunday night to whoever is picking up ILAP forms. Then sometime the following week someone from ILAP will come pick up your ARP form.
42. I am afraid that because of my chronic medical conditions, I am particularly vulnerable to coronavirus.
43. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 6, 2020

Signature:

A handwritten signature in black ink, appearing to be 'J Tom', written over a horizontal line.

Joshua Tom signing for Bob Henderson of Greene County, Mississippi

Witness Signature:



Dated: May 6, 2020

I, Matthew Lawrence am an attorney barred in Mississippi. On May 6, 2020, I joined a phone call with the Declarant and the above-listed attorney. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on his behalf.

Re: Bob Henderson Declaration

EXHIBIT 7

DECLARATION OF THOMAS HOLDER

I, Thomas Holder, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I currently live at South Mississippi Correctional Institution (SMCI). I have lived here for about eleven years. I am 64 years old.
2. I live in Building D1, B-Zone, and have for approximately over a year, most recently. I live in an open bay zone with about 100 other people. We sleep in bunks that are close together. This zone is one of two in our building, so about 200 people live in our building.
3. This zone has a significant population of older people and of people with chronic medical care needs. This zone is also a working zone. Many of those who can work have jobs all over the prison by day. At night, they come back here. Among other jobs, they do laundry jobs, cleaning jobs, they're kitchen workers, and they're dining hall workers.
4. I suffer from diabetes and cancer on my face. I also have bipolar disorder, type one.
5. I am currently under the care of a physician for the cancer on my face, which I had surgery for about a year ago; and for bipolar disorder, which I was diagnosed with over twenty years ago and which I take prescription medication to treat. I was diagnosed with diabetes about fifteen years ago and previously took medication to control it. The cancer has bubbled up on my face again and I am awaiting more surgery to treat it.
6. The cancer on my face is disfiguring. The skin bubbles up with fluid that sometimes leaks. The diabetes is better controlled than it was, but I can still tell when my blood sugar gets low or high.
7. I have the most serious form of bipolar disorder, type one. If I am not treated or if I become very stressed, I cannot sleep. I get manic, wired, grit my teeth, go from one extreme to the other. I get real wild. It gets bad. If I get stressed out, I can start to have symptoms, like getting very agitated and having trouble sleeping. Before I was diagnosed, I self-medicated. Bipolar disorder is in my family. Older members of my family never got the right medicine.
8. I have been getting stressed out because the coronavirus is in MDOC and I do not feel like they are doing enough to prevent an outbreak. This stress is making me have symptoms, like being agitated and anxious. I suffer from underlying medical conditions and fear for my safety, health, and life.
9. There is no soap available in the bathroom—you have to bring your personal bar of soap in and out if you want to use it.
10. The state provides us with a bar of state soap every week, but if you have personal

laundry washing to do, that can use it up.

11. We do not have disposable paper towels for hand washing or hand drying machines.
12. We do not have face tissues.
13. We get one role of toilet tissue every week to use for both our bathroom and facial tissue needs. If you are sick and use your toilet tissue more to cough or sneeze into, you have less toilet tissue for the week for using the bathroom. I have run out of toilet tissue before. They won't give you more. You have to trade or buy some off the zone, and not everyone can do that.
14. I received a flu vaccine on or around October of 2019.
15. On our zone, which has a lot of older people and chronic medical care patients, nurses do insulin call at about 3:00 a.m. on the zone and at about 3:00 p.m. at the rear administration building, which is about 75 yards away from our building. That building has the dining hall and the canteen window. Nurses do pill call there sometime between 9:00 a.m. and 11:00 a.m. They do pill call again on the zone at about 10:00 p.m. to 11:00 p.m.
16. When the nurses come on the zone for pill call and insulin call, nobody lines up six feet apart. No one has told us we need to stand six feet apart. When people who go to morning pill call or afternoon insulin call which takes place at the canteen window at another building, nobody lines up at the window six feet apart or walks the distance to the next building, where the dining hall is, six feet apart. No one has told us we need to.
17. We are getting about thirty minutes of yard call most days, which is pretty new. We had not been getting yard call regularly for a long time. On the yard, people are not standing six feet apart. No one has told us we need to stand six feet apart.
18. When we are in the dayroom or eating, we do not sit with extra space between us, and we do not sit six feet apart. It would be impossible to do so. No one has told us to try.
19. Typically, if I fill out a sick call slip and submit it, it takes a couple of days to get seen. I have not heard of any speedier process by which to be seen by medical staff if we have symptoms of coronavirus.
20. The sick call form has a place at the bottom where you have to sign to agree that they'll charge you six dollars to be seen. They are not supposed to charge for chronic care visits, but they still try to. It happens all of the time that people are sick on the zone and do not put in a sick call slip to see medical because they do not want to be charged the six dollar fee. If you are saving up money for canteen, six dollars can blow your savings.
21. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or coughing and fever. I know that people avoid going to medical when they are sick because they do not want to pay the six

dollars.

22. I wanted to file an ARP about MDOC not doing enough to keep us safe from coronavirus. I was told that a Captain had informed residents on the zone that if we file an ARP, we will get moved to the other end of the compound, where it is more violent and people get killed more often. So I am scared to file an ARP. I'm an old man, and I can't handle all of that. I feel like there is not a way I can use the grievance system to challenge MDOC's practice around coronavirus prevention.
23. I am afraid that if I am exposed to coronavirus, it could me very sick very quickly because of my medical conditions, and that they would not isolate me for others' safety and I might not be able to get the help I need on time.
24. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 8, 2020

Signature:

A handwritten signature in black ink, appearing to read 'Paloma Wu', written over a horizontal line.

Paloma Wu signing for Thomas Holder of Greene County, Mississippi

Witness Signature:



Dated: May 8, 2020

I, Matt Lawrence, am an attorney barred in Mississippi. On May 8, 2020, I joined a phone call with Declarant Thomas Holder and attorney Paloma Wu. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the attorney to execute it by signing on the Declarant's behalf.

Re: Declaration
Thomas Holder

EXHIBIT 8

DECLARATION OF OZIEL GUZMAN

I, Oziel Guzman, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. My father, Juan Guzman, has been incarcerated at South Mississippi Correctional Institution (SMCI) since 2017.
2. My father speaks and reads Spanish. He does not speak or read English. He knows other Spanish-speaking individuals at SMCI.
3. My family is close. I talk to my dad by phone just about every evening. I have spoken to him often about the coronavirus pandemic. I last spoke to him yesterday evening.
4. My dad and I have discussed what information MDOC has provided about the coronavirus and what he can and should do to protect himself and others. My dad told me that he has not seen or heard communicated any such information in Spanish. He told me he does not know what MDOC wants residents to do or not do should they fall ill with it or to prevent infection.
5. Me and my family are very worried about my father because he is almost 65 years old. I am afraid that because Spanish-language information about coronavirus is not available where he lives, he is more likely to contract the virus and less likely to know how best to get the help he needs should he become infected.
6. I believe my father recently was tested for tuberculosis and received treatment.
7. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person meetings during the coronavirus pandemic.

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

Dated: May 8, 2020

Signature:



Paloma Wu signing for Oziel Guzman of Cameron County, Texas

Witness Signature:

A handwritten signature in black ink that reads "Amelia S. McGowan". The signature is written in a cursive style with a long horizontal flourish at the end.

Dated: May 8, 2020

I, Amelia McGowan, am an attorney barred in Mississippi. On May 8, 2020, I joined a phone call with Declarant Oziel Guzman and the above-listed attorney Paloma Wu. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on his behalf.

EXHIBIT 9

DECLARATION OF DERRICK GUYTON

I, Derrick Guyton, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746:

1. I live at Parchman, in MDOC's hospital unit, Unit 42, in Room 217. I have lived in Unit 42 for about five years. I am housed here because I have multiple sclerosis. I was diagnosed with multiple sclerosis about twelve or thirteen years ago. I cannot walk. I am very weak. I use a wheelchair. I need help using the bathroom. I have a catheter in my bladder. I have had part of one leg amputated.
2. My room, Room 217, has two beds in it, very close together. The beds are about three feet apart. My wheelchair fits between the beds with a little extra space. The room has one shared toilet and one shared sink.
3. Unit 42 holds between 40 and 50 people. Many people need twenty-four-hour care. Probably about 30 of us have very serious chronic medical care issues. Many people who come here pass away here.
4. At some point in the last few weeks, a resident named Earl was admitted to Unit 42. I believe it was on a Sunday. He was admitted as my roommate. I was shocked when I first saw him. His whole face was pale. If you would have just seen him—he looked like the walking dead. He was so weak he couldn't hardly talk. He kept coughing.
5. Earl was able to tell me that he had come to Unit 42 earlier, on a Saturday, I believe, initially, but that they refused to admit him. He said they sent him back to Unit 26 with just a cold pack and Tylenol. But he was so sick, he was sent back to Unit 42 the next day, I believe a Sunday. They finally admitted him here.
6. Earl stayed in Room 217 with me the entire time he was at Unit 42. The rooms are so small, it is impossible not to hear everything that is said by medical staff in the room.
7. I heard Earl, from the very first day he was admitted, tell every medical staff member who visited him that he was in the worst pain of his life, that he couldn't swallow because the coughing was so bad, and that he felt like he was choking to death. Earl was coughing so much—it was like he couldn't stop. When he slept, he'd be coughing. When I fell asleep, I'd fall asleep to him coughing. When I woke up, he'd be coughing. It seemed like he wasn't sleeping—that he was just coughing.
8. I asked for masks for both of us the second day he was in here. They wouldn't give him a mask. They wouldn't give me a mask. While we lived together, they never gave him or any resident masks that I saw. I kept trying to cover up my face with my blankets or a sheet. I was afraid he would be offended. But he never got mad. He couldn't hardly talk—it sounded like he was choking when he tried.

9. I heard the medical staff every day say that Earl had a fever. Sometimes it was a higher or a lower fever, but he had a fever every day he was here.
10. Earl repeatedly asked the nurse for a liquid diet because he was coughing so much he couldn't swallow. He told staff he had been unable to swallow or eat food since before he was admitted to Unit 42—because he was sick on the housing unit. Earl never got a liquid diet that I saw, and I saw all of the meals he got every day. He could not eat the food on the regular trays. He would throw it out or give it to me to eat, and I ate some of his food.
11. When we were both in the room, the medical director, I believe his name is Mr. Gleeson, told Earl that Earl just had a bad case of pneumonia. That's what all the other nurses repeated after that. They gave him some antibiotic shots and a pill, maybe a pain pill. Then for three days straight, they gave him that antibiotic shot: I believe it was on a Monday, Tuesday, and Wednesday. I take that same shot when I get infected. Earl told me he thought he didn't have pneumonia and that he had the sickness that people on TV were dying from.
12. The entire time Earl was housed here, Earl was allowed to move around the unit however he wanted to. We would use the same shower, the same phones, the same everything; he shared his tray with me. The staff took absolutely no steps to separate or isolate him.
13. I was with him when he made a phone call. He could barely get words through his cough. All of the residents share the same wall phones.
14. While he was here, he came into the dayroom. Many residents would be there. Residents here have serious, chronic medical conditions. The dayroom is not big. It's a tight fit. Earl would be coughing. The man never stopped coughing.
15. Mr. Gleeson and the nurse practitioner just work, I believe, on Monday through Thursday. On Friday, there is a different doctor. We call him Dr. Tony. He is an incredible doctor. He treats us like human beings. On Friday, Dr. Tony came into our room for the first time since Earl had been admitted. Dr. Tony looked at Earl, who was coughing, for not more than two minutes—he checked Earl's temperature and said he had a fever. Dr. Tony said, "We got to get him out of here fast." He told staff to call a hospital right away. An ambulance came and took Earl out on a stretcher. Earl's condition—the coughing and fever and him looking half-dead—wasn't more obvious on Friday than it had been from the day he was admitted.
16. Earl never got a mask at Unit 42.
17. I never heard the word coronavirus used by hospital staff until after Earl died. I found out Earl had died because one of the nurses told me, "You better hope you don't have coronavirus," because Earl had died and that's what he died of. I could hardly believe it. I truly believed he had pneumonia because that is what the doctor said.

18. After Earl died, they took me out of our shared room and had it sprayed with something. They put me in another room. It said "Isolation Room 2" on the door. There are only two rooms total marked "Isolation Room" in Unit 42. I asked them for a coronavirus test. They initially didn't want to give me one. The nurse director told me that. I don't know why. I asked again, and they finally gave one to me.
19. When I was tested for coronavirus, they stuck a very long swab up my nose. I never saw them do this to Earl while he was in Unit 42. I did see them take his blood.
20. After Earl died, I was in the isolation room for about two or three days, then they released me. I was released right after a nurse told me my coronavirus test came back negative. When I was released, they put me into Room 226 with two other people. I think one of them had cancer and another is paralyzed. I do not recall anyone checking in on us twice a day to check our temperature and whether we had symptoms of coronavirus. I was in Room 226 for about two days, then they moved me back to Room 217, the room I shared with Earl. When I moved back into Room 217, I had a new roommate. That new roommate was very ill with a disease. I do not recall anyone checking in on us twice a day to check our temperature and whether we had symptoms of coronavirus.
21. There are some individual medical staff here who are great—a couple of nurses in Unit 42 are as good as gold, and Dr. Tony is an incredible doctor. But the medical care provided here is not like a hospital—I have been to outside hospitals. The unit is understaffed. Some days, for example, there is one CNA or, at night, there are none. The call button in the bathroom doesn't work or is never answered.
22. I am concerned that lack of staffing and precautions taken to prevent and manage coronavirus in MDOC will mean I and others—especially the very medically vulnerable people in my unit—will become ill and die unnecessarily.
23. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 11, 2020

Signature:



Paloma Wu signing for Derrick Guyton of Sunflower County, Mississippi

Witness Signature:



Dated: May 11, 2020

I, Matt Lawrence, am an attorney barred in Mississippi.
On May 11, 2020, I joined a phone call with Declarant Derrick Guyton
and attorney Paloma Wu. On that call, this declaration was read verbatim
to the Declarant. The Declarant then verbally directed the above-listed
attorney to execute it by signing on the Declarant's behalf.

Re: Derrick Guyton
Declaration

EXHIBIT 10

DECLARATION OF ERIK LEWIS

I, Erik Lewis, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at South Mississippi Correctional Institution (SMCI). I have lived here for approximately one year. I am 38 years old.
2. I currently live in Building C1, A Zone, Bed 80, and have for approximately one year. A Zone is one big room with bunks, an open bay zone. About 98 or 99 people live on this zone which is designed for 100. This zone is one of two in our building, so about 200 people total live in this building. I believe there are 13-14 buildings like ours at SMCI.

Overcrowding

3. Each person sleeps within 2.5-3 feet of another. I can reach my arm and almost touch the guy next to me. I understand that these zones were designed for fewer than 100 people and that these buildings were designed for fewer than 200 people each.
4. Each zone of 100 people has double racks, or bunk beds. There is wall down the center of the zone with bunks on either side, but you can see over the wall from a bunk. There is far less than six feet between racks horizontally and vertically. We are packed in here. Not much room in the walkways or at all.
5. We do not sleep head to foot. Everyone sleeps however they want. No one has told us to do otherwise.
6. It is physically impossible for us to maintain more than a few feet of distance between one another, and we have not been told to try to do so. The common area consists of a few tables and a couple of benches and a TV.
7. For the around 100 men who live on a zone, there are 5 sinks that work, 2 working toilets, 2 working urinals, and 2 working phones. It is difficult to get a call on the phones. There is usually a line for the phones and people use them continuously during the day. We have to do everything on the phone – canteen, call loved ones. We have 2 phones for 100 people, you can imagine the line. I have not seen the phones been cleaned. There is not regular cleaning of the phones.

Social Distancing

8. When the nurses come for pill call, nobody lines up six feet apart. There is no social distancing during this time. There is no such thing as social distancing in this prison. We don't even hear that word. That is not practiced here. No one tells us we need to stand six feet apart. There is no one practicing social distancing anywhere in the zone or at the ILAP office or anywhere else I've seen in the facility.

9. We have guys trying their best to keep their distance and stay safe, but there is no help from MDOC. It's every man on his own.
10. We get no instructions, no talk of any testing going on. We don't know what's going on with COVID. We have guys in here, coughing, chest pains, persistent coughs and medical does not respond. We're like sitting ducks, ready to die. Lot of people not getting help out in the world, what about us in here. We know we're dead.
11. Since the pandemic, I try to stay in my bunk with sheets around me to stay safe. It's all I have, as inadequate as it is. And they call putting up sheets a security breach because they can't see me. They haven't given us anything except a bar of Dial soap and a mask made from a sheet and a pair of rubber cleaning gloves. What about social distancing and cleaning supplies? Guards, kitchen staff, legal department, medical staff all interact and come into the zone. We are not isolated in here from the outside. The virus could be brought in from all these people coming to the zone from the outside.
12. Officers don't take this seriously. Some have their mask on, some have it half way on, most don't wear it at all. They are putting us at risk.
13. We need antibacterial soap for everything and all we have is one Dial soap, no bleach; there's trouble keeping the ventilation on, and the ventilation is inadequate in the best of times. We try to stay informed – COVID is an air born disease, and there are no precautions taken to protect us from that.
14. MDOC is the reason I'm in danger from the pandemic. It's their responsibility to keep me from harms way, and we are sitting ducks.

Staff Absence

15. I have witnessed situations where a resident tried to get medical help but no staff member was around, or a staff member was around but failed to respond. This happens every day. For example, if an inmate has a seizure, we first have to convince the tower guard it's an important issue. We have to set fires, almost knock the door down to get medical attention. It all depends on the tower officer. If she wants to, or is in the right mood, you may or may not get help. Some officers are incompetent, some just don't care. Some officers cover the windows, so she can't see us and we can't see them. This happens regularly.
16. SMCI is very understaffed. There is usually just one guard watching us from the building's one tower. Each building of 200 people is composed of two zones of 100 men each. The building's tower sits between the two zones. It is not possible to observe both of the building's two zones from the tower at the same time. The windows over one zone are at least twenty feet away from the windows that look over the second zone. There are supposed to be three officers and a supervisor for the building, to oversee both zones, and to watch for medical and other emergencies. Instead there is often only 1 staff in the entire building.

17. We might see an officer work 14, 15, 16 hour shifts because they are so understaffed. They're exhausted, tired, irritated, they don't want to be bothered by an inmate and his problems. They're so stressed and overworked, they don't care and just want to go home.
18. One night in late April 2020, at 9:30 or 10pm at night, there was no tower officer for over an hour in the tower, so no officer is available to respond to any needs that arise from the individuals in our building. This is dangerous because if a prisoner has an emergency or medical needs, he can't be helped. If he has coronavirus symptoms, he needs to be removed and isolated as soon as possible so he can receive treatment and to try to prevent the spread of coronavirus to other prisoners but that can't happen.

Medical Conditions

19. I suffer from asthma. I was diagnosed with chronic asthma in 2009. I have real bad migraines.
20. I haven't been tested for COVID. I don't know if the symptoms I have are COVID or what. We don't have access to the information or anyone to educate us about the virus.
21. I am currently under the care of a physician for my asthma and take prescription medication for treatment using an inhaler.
22. My asthma makes me short of breath all the time. Due to the shortness of breath, I become winded easily doing any kind of strenuous activity (even talking), and it is especially bad during summer months. I also wake up in the middle of the night often because I can't breathe. We have no air conditioning and 100 people, so it's even warmer in here, and my symptoms get worse in the hot months.
23. When I have not received adequate treatment for this asthma, I experience shortness of breath, which has prevented me from being able to talk and walk without becoming extremely winded. During the summer, I have to slow down during the hottest parts of the day. I usually have to sit in front of my fan every day until around October when the weather cools off.
24. Because coronavirus is in many prisons, and I suffer from underlying medical conditions, I fear for my safety, health, and life.

Cleaning

25. An inmate gave us a pink liquid and told us to clean with this. I have no idea what it is, but you can tell it's diluted. We get this liquid 4-5 days per week. We try to clean the water fountain, sinks, telephone, microwave, day room, but it's not enough to clean everything in the common areas. We have to clean certain things and not others. We use torn up sheets and towels to apply this liquid. There's nothing else to use to apply the product except tissue paper. Anytime we ask for more disinfectants, they tell us, "I

don't know." That is if they say anything at all.

26. Cleaning is not enforced. If we don't do it, it won't be done.
27. Much of the space of the zone is taken up by bunks. We spend much of our time in these living areas. We are not being provided with chemicals to clean these areas. I try to clean my bunk area with the Dial soap and water and use a torn sheet or towel to clean. They only give us three towels. I have to sacrifice one of my towels to clean my bunk area.
28. I trade food for extra soap, so I can keep my space clean. I've traded food, canteen, a towel to get disinfectant. This kind of bartering is not possible for many people. One missed meal would be devastating for some people because they are barely hanging on.

Hand Hygiene

29. There is no soap available in the bathroom—you have to bring your personal bar of soap in and out if you want to use it.
30. The state provides us with one bar of state soap on the 4th of the month and the 14th of the month and on the 24th of the month. It is smaller than a hotel bar of soap.
31. I do not have enough soap to wash my hands regularly and shower.
32. The prison gave us one bar of Dial soap because of coronavirus at the end of March and the beginning of May. The first bar was used up in 5-6 days.
33. The state soap the prison provides irritates my skin but you have to use it. It dries your skin out. It feels like you have ants crawling all over you every day. I always avoid using the soap because it irritates my skin, but I use it if I have to.
34. We do not have disposable paper towels for hand washing or hand drying machines. We have three towels and toilet paper.
35. We do not have face tissues. We get one roll of toilet tissue on the same schedule as the soap. If you are coughing or sneezing and you use your toilet tissue, you have less toilet tissue for the week for using the bathroom. If you run out you have to buy more. I have to buy 2-3 rolls more every week. Not everyone can buy more tissue, so they just run out, and gotta do what they gotta do. That's where that extra towel or t-shirt comes in.
36. We do not have hand sanitizer.

Communication

37. SMCI's response to COVID-19 has been minimal. I receive my information about the pandemic by watching the news. I saw one flyer posted in the zone with someone coughing, but when I came back, it was gone. It was only in English.

- 38. No additional information about coronavirus or how to reduce risk around it has been communicated.
- 39. In fact, there is a lot of disinformation going around, same as outside, but they are harder to dispel in here, like if you're black, you can't get sick.
- 40. You have some guys with limited education and combined with the limited to no information about the pandemic, people have no idea what's going on.
- 41. They are not trying to keep us safe in here.

Protection

- 42. Only a few guards wear masks. Some incarcerated people try to keep themselves safe and wear masks, but most don't. I see 4 people out of 99 wear a mask.
- 43. Around the end of April, medical staff started to wear masks.
- 44. If someone has COVID symptoms, I have seen no response from SMCI.
- 45. I have not received a flu vaccine, and I can't remember the last time I was offered it.

Sick Call

- 46. Typically, if I fill out a sick call slip and submit it, it takes about three days to get seen by medical staff. Even if I put "emergency" on the sick call, it will still take a day or two to be seen. I also have to fill it out perfectly, or else they won't see me. To submit a sick call request, I have to go to the tower and try to get their attention. If there is a sick call slip in the tower, they'll give me one. A lot of times, especially during cold and flu season, they won't have any sick call slips. There are no sick calls in the tower now, as I say this, May 7, 2020, because I tried to get one this morning.
- 47. I have seen someone die from a stroke and SMCI did not respond in time. It took them 40 minutes to come, and they took him out dead. After the tower officer made the call, she just sat there and did nothing more. This was end of January 2020. We have guys come up dead often in this building with inadequate medical response.
- 48. I have not heard of any process to be seen by medical staff sooner if we have symptoms of coronavirus.
- 49. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or coughing and fever. I know for a fact that it is not on the sick call forms. Some people would not want to go to medical to be charged six dollars for that sick call form. A lot of people can't even afford six dollars.

Six dollars is two bars of soap, 5-6 meals; it's a lot of money.

Grievances

50. Typically, if I submit a grievance, or ARP, it takes a week or more to receive a response. To submit an ARP, I have to depend on someone going from building to building to put the form in. I usually have to wait on the bench all Sunday for someone to come by, because there is no set time. After I submit it, they're supposed to call on Wednesday. I also have to fill out the form perfectly, or I'll have to wait another week to start the grievance process all over again. They have 45 days to respond, but in reality it is more like 4 months. Sometimes you never hear back at all. Once they respond, I have 15 days to respond back. If I don't respond within the time limit, they will kick my grievance out.
51. I have submitted an ARP at the beginning of April about MDOC not adequately protecting us from coronavirus and not providing enough staff to help us if we have illnesses or coughing or fever or think we might have coronavirus. I have received no response, and I don't expect to hear back given the ARP process.
52. Based on my experience with MDOC's grievance system, I do not expect a meaningful, if any, response. The ARP process at MDOC is so unreliable, confusing, and lengthy that I can't see how any relief—even if granted—could prevent me or others getting sick or dying due to a preventable coronavirus outbreak.

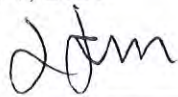
Other

53. I am afraid that if I am exposed to coronavirus while detained and need help, I would become ill extremely quickly because of my medical conditions, and I would not be able to get help in time to survive.
54. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 7, 2020

Signature:



Joshua Tom signing for Erik Lewis of Greene County, Mississippi

Witness Signature:

A handwritten signature in black ink that reads "Amelia S. McGowan". The signature is written in a cursive style with a long, sweeping underline.

Dated: May 7, 2020

I, Amelia S. McGowan, am an attorney barred in Mississippi. On May 7, 2020, I joined a phone call with the Declarant and the above-listed attorney. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on his behalf.

EXHIBIT 11

DECLARATION OF DOUGLASS TRIPLETT

I, Douglass Triplett, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at South Mississippi Correctional Facility (SMCI). I have lived here off and on since 2014. I am 56 years old.
2. I currently live in Building D1, B Zone, Bed 159, and have since February 5, 2020. This Zone is an open bay. There are 100 people in a zone, and 2 zones per building, so there are 200 people in a building.

Overcrowding

3. The zone is a large open room with rows of double bunk beds. There are 98 beds being occupied now. There are 8 tables and 32 stools to accommodate 100 people. We are all really close together all day long.
4. There might be three feet between racks horizontally and vertically. We are packed in here. There are too many people in here. If one person gets COVID, everyone will get it. The one mask and rubber gloves they gave us won't protect us from the virus.
5. We do not sleep head to foot. Everyone sleeps however they want. No one has told us to do otherwise.
6. It is physically impossible for us to maintain more than a few feet of distance between one another, and we have not been told to try to do so.
7. For the approximately 100 men who live in this zone, there are seven sinks and five work, six toilets and five work, four urinals, and three phones, two of which work. It is difficult to get a call on the phones. There is usually a line and people use them continuously during the day.

Social Distancing

8. When the nurses come for pill call, nobody lines up six feet apart. No one tells us we need to stand six feet apart.
9. When we are in the dayroom, we do not sit with extra space between us, and we do not sit six feet apart. No one tells us to.
10. There are no social distancing efforts being taken in this zone or this facility that I've seen. When we go to medical, they pile us up in one room. When we see the nurse, there is no social distancing.

Staff Absence

11. I have witnessed situations where a resident tried to get medical help but no staff member was around, or a staff member was around but failed to respond. For example, I have seen guys get stabbed, their head stomped and there was no guard in the tower. Other times, even if the guard is in the tower, I have seen them wait till the guy is beaten to death till they do anything, and then it takes 30 minutes or longer for someone to come to assist.
12. SMCI is very understaffed. There is not enough staff to take care of all inmates. There is usually just one guard in the building's one tower trying to watch 200 people. One guard may have to work two shifts. I've seen some work long hours, more than 12, 13, 14 hours straight, and they get tired. I've seen guards stay at work so long, they walk off the job and leave the tower unattended. Some guards have to work two buildings, leaving one building of 200 people unattended for hours at a time. I've seen this plenty of times.
13. When no tower officer is present, there is no means by which a resident can get help, which is dangerous. For example, a guy had chest pains, like a heart attack, and we needed to call an officer and get medical attention, but there was no staff present. We had to kick on the door to see if we could get someone walking by on the sidewalk. Some people have been beaten to death and would have lived if they had gotten swift medical treatment, but they did not.
14. The tower guards frequently paper over the windows, so no one can see in or out. For the night shift, sometimes they will paper over the windows for the whole night.

Medical Conditions

15. I suffer from HIV and paranoid schizophrenia. I was diagnosed with HIV approximately 26 years ago and paranoid schizophrenia in the 1970s. I also have high cholesterol.
16. I am currently under the care of a physician for my HIV, but I have not been treated for my paranoid schizophrenia since 1999-2000. I take prescription medication for treatment.
17. My HIV makes me extremely weak, lethargic and immobilized, along with lesions on my face. I also have little to no appetite with terrible pain in my stomach. Because of these symptoms, I cannot exercise like I normally would. I also am not supposed to be in sunlight, so I cannot often go outside.
18. Because coronavirus is in many prisons and I suffer from underlying medical conditions, I fear for my safety, health, and life. My immune system is vulnerable. I'm at a handicap already, and if I get coronavirus I doubt my system will be able to fight it.

Hand Hygiene

19. There is no soap available in the bathroom—you have to bring your personal bar of soap in and out if you want to use it.
20. The state provides us with a bar of state soap twice a month.
21. The prison gave us a bar of Dial soap because of coronavirus around the beginning of April and the beginning of May. I try to make mine last a month until they give me a new one because I don't have any money to buy more.
22. The state soap the prison provides irritates my skin. It feels like something is biting me. I sometimes avoid using the soap because it irritates my skin.
23. We do not have disposable paper towels for hand washing or hand drying machines.
24. We do not have face tissues. We get toilet tissue twice a month for both our bathroom and facial tissue needs. If you are coughing or sneezing and you use your toilet tissue, you have less toilet tissue for the week for using the bathroom. I have run out of toilet tissue before. Lots of people run out of toilet tissue. It's hard to make that tissue last especially if you have a cold or sinus problem. Guys walk around trying to buy other guy's tissue regularly.

Communication

25. I've seen no flyers or information about the coronavirus in my Zone.
26. No additional information about coronavirus or how to reduce risk around it has been communicated.
27. In fact, a man named Harrington, who I think is the Superintendent, took us into the yard a month or so ago and told us not to call our families and tell them the coronavirus was in the facility. If he got a call from a family member saying the virus was in the facility, he would come back here, and we wouldn't like it. It sounded like a threat.

Protection

28. Around the beginning of April, all of the imprisoned people on my zone received masks. They appear to be a single layer of bedsheet fabric. Not many people – whether staff or incarcerated people – wear them whether they are in the Zone or outside the Zone. When I went to the ILAP office, one of the women did not have a mask on. The Captain visited the Zone on May 11, and he didn't have a mask on.
29. Most of the medical staff wear masks, but I have seen some of them not.

Sick Call

30. Typically, if I fill out a sick call slip and submit it, it takes 4 to 5 days and sometimes up to a week to get seen by medical staff.

31. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or coughing and fever. Some people would not want to go to medical to be charged six dollars for that sick call form.

Grievances

32. I would like to submit an ARP, or grievance, about the need for MDOC to take more steps to prevent coronavirus from harming us. However, I would need help filling out an ARP. In the past, many years ago, law library staff used to help us fill out ARPs if we couldn't by ourselves or didn't know how to. That is not the case anymore. I can't fill out an ARP form by myself because I don't know how. I don't know how to compose it, put it together in the proper manner.
33. I'm afraid of retaliation by MDOC if I submit a grievance or complain against them, like being moved to the high-risk building. I've seen people be retaliated against many times when they complained, and there is no accountability I've seen of MDOC.

Other

34. I am afraid that if I am exposed to coronavirus while detained and need help, I would become ill extremely quickly because of my medical conditions, and I would not be able to get help in time to survive.
35. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

Dated: May 12, 2020

Signature:

A handwritten signature in blue ink, appearing to read 'Joshua Tom', written over a horizontal line.

Joshua Tom signing for Douglass Triplett of Greene County, Mississippi

Witness Signature: _____/s/: Rob McDuff_____ Dated: May 12, 2020

I, Rob McDuff, am an attorney barred in Mississippi.
On May 12, 2020, I joined a phone call with the Declarant and the
above-listed attorney. On that call, this declaration was read verbatim
to the Declarant. The Declarant then verbally directed the above-listed
attorney to execute it by signing on his behalf.

EXHIBIT 12

DECLARATION OF BRENT RYAN

I, Brent Ryan, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I live in MDOC's hospital unit, which is located on the grounds of Mississippi State Prison at Parchman (Parchman) at Unit 42. Before coming to Unit 42, I was housed at South Mississippi Correctional Institution (SMCI). In January of 2018 at SMCI, I was hurt and became paralyzed from the neck down. After being on a ventilator and hospitalized for about five or six months, I was placed at Unit 42 because I require twenty-four hour medical support. I am now quadriplegic. I am 41 years old.
2. There are about forty people housed in Unit 42. I believe between twenty and thirty residents here are bed-bound and need help doing everything, from bathing to toileting. I believe about fifteen people are usually housed here because they are very sick and need some chronic treatment that can't be given on the housing unit infirmaries.
3. A few weeks ago, a man named Earl Dycus was brought to Unit 42. He came here from Unit 26. When I met Earl, he had an absolutely terrible cough. They put him in a room with my former roommate, Mr. Derrick Guyton. For the entire time Earl was housed here, he was housed with Mr. Guyton in Room 217. My room is Room 215. In our small shared rooms, you can hear everything that's said.
4. During the time that Mr. Guyton and Earl were housed together, Mr. Guyton told me that he was present in the room and heard medical staff tell Earl that he just had bad pneumonia. During that time, Mr. Guyton told me that Earl was coughing all of the time and was extremely ill. During that time, Mr. Guyton also told me that Earl told him he had been sent twice from his housing unit, Unit 26, to Unit 42 for treatment for his cough and illness, and that the first time he had been refused admission to Unit 42 and was sent back to his housing unit.
5. Earl was never isolated the entire time he was in Unit 42. His roommate, Mr. Guyton, is an amputee and is wheelchair bound. While he was at Unit 42, Earl was within six feet of many medically vulnerable people for long periods of time. He came into the dayroom with many of us, which is not big, and he would be coughing everywhere. He looked awful. He looked and acted incredibly ill. He was always coughing.
6. I never saw Earl or Mr. Guyton wearing a mask during the time Earl was in Unit 42. None of the patients in Unit 42 had masks when Earl was housed here.
7. Earl was finally taken out of the unit. I learned he died of coronavirus. After Earl died, they put his roommate, Mr. Guyton, in isolation and washed the room they had shared, Room 217. I am still housed in Room 215, which is directly across the hall from the dayroom, which Earl visited while he was housed here.
8. The week following Earl's death, staff asked me if I wanted a mask for the first time.

9. I was never tested for coronavirus. I was repeatedly within six feet of Earl when he lived here and was coughing. To my knowledge, the only person I know who was tested for coronavirus after Earl's death was Mr. Guyton.
10. Since Earl's death, I have recently noticed that it appears they have started isolating for some amount of time people who return from outside doctor appointments. I believe this has been since on or around April 23, 2020. Also, recently, I believe some people have been admitted since Earl's death for coronavirus testing, and they have not been assigned roommates.
11. Unit 42 is often understaffed, and there is a high turnover rate for medical staff. For example, the other night, there were two nurses for forty-two patients. They had no CNA or trustee support. The nurses were providing the medical care, then changing diapers, changing bedsheets, then emptying the trashcans, and nobody was here to do laundry. It causes a big mess. This level of understaffing probably happens about once a week. During the time I've been housed here, I've seen dozens of nurses quit. Some individual staff members are extremely hard-working. They are often just left unsupported.
12. Because of the understaffing, I sometimes go an entire day needing a diaper change and having to sit in feces. I am sometimes not bathed or helped out of bed for a week at a time.
1. I am concerned that lack of staffing and precautions taken to prevent and manage coronavirus in MDOC will mean I and others—especially the very medically vulnerable people in my unit—will become ill and die unnecessarily.
2. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

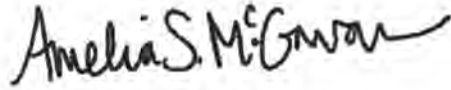
Dated: May 8, 2020

Signature:



Paloma Wu signing for Brent Ryan of Sunflower County, Mississippi

Witness Signature:

A handwritten signature in black ink that reads "Amelia S. McGowan". The signature is written in a cursive style with a long, sweeping underline.

Dated: May 8, 2020

I, Amelia McGowan, am an attorney barred in Mississippi.
On May 8, 2020, I joined a phone call with Declarant Brent Ryan and
the above-listed attorney, Paloma Wu. On that call, this declaration was
read verbatim to the Declarant. The Declarant then verbally directed the
above-listed attorney to execute it by signing on the Declarant's behalf.

EXHIBIT 13

DECLARATION OF TONY SMITH

I, Tony Smith, declare the following under penalty of perjury pursuant to 28 U.S.C § 1746:

1. I am currently imprisoned at Central Mississippi Correctional Facility (CMCF) in Rankin County, Mississippi. I am at CMCF awaiting outside medical care that has been delayed because of the pandemic. I am 58 years old.
2. I lived at Mississippi State Prison at Parchman for about twenty years and was employed at an inmate job throughout that time. Working and having a job is very important to me. We are locked down at CMCF right now because of the pandemic, and I can't work at my job. I am anxious, stressed, and going stir crazy because I can't go to work.
3. The vast majority of imprisoned people who have jobs do not get paid. I spent the first decade in educational and vocational school and was a teacher's aide during that time. That work was unpaid. For about the past decade, I've worked full time for Mississippi Prison Industries Corporation (MPIC) and have earned wages. We sew the clothes residents wear, and I do maintenance for the equipment and building. When at Parchman, I worked full time, during normal business hours, five days a week.
4. A sick call fee of \$6.00 is charged to any imprisoned person's account who is sick and wants to be seen by medical for help. That charge is nearly a week's wages of full-time work for residents that have one of the rare paying jobs at MDOC. Starting employees at MPIC earn about \$0.20 per hour. After a decade as an employee, I earn the highest rate: \$0.38 per hour. I have earned that wage for seven years, as it is capped there.
5. I have not heard or read anything about MDOC waiving the six-dollar fee for sick call for medical visits related to the coronavirus or coughing and fever. I know many people who avoid going to medical when they are sick because the \$6.00 fee. I know some would hesitate to see medical if they felt they had symptoms of coronavirus because of the fee.
6. At CMCF, I live in Building B2, C-Zone, and have since February of 2020. It is an open bay zone, with 100 people in bunks. The building has another identical zone, so 200 individuals live in this building.
7. This buildings and others close by are part of the medical camp: Buildings A, B, and now there are some in C. There are a lot of folks in wheelchairs. This building is where they house people who are waiting to get sent to an outside medical appointment. Not everyone who lives in these buildings are chronic care medical patients, but there are a good number of us.

Overcrowding & Social Distancing

8. My zone and building are overcrowded. I understand that these zones were designed for

- fewer than 100 people and that these buildings were designed for fewer than 200 people each.
9. My understanding is that all of the residential buildings on this side of the compound are like mine: Building A1 (containing zones A and B); Building A2 (containing zones C and D); Building B1 (containing zones A and B); Building B2 (containing zones C and D); and Building C2 (containing zones C and D) each have 200 residents. Other buildings at CMCF may also be overcrowded like ours.
 10. The 100 people in each zone mostly live in their beds, or racks, since these living spaces take up about three-quarters of the entire amount of space on the zone. The common area consists of a few tables—four of them with four seats each.
 11. The 100 men sleep and live in six rows of bed on the rectangular zone. Starting at the back wall, the bed types in each of the six rows are as follows: a row of double racks (or bunk beds), a row of single racks, a row of double racks, a half-wall, another row of double racks, a row of single racks, and a row of double racks at the front wall. The double racks run from wall to wall on the two outside walls. The four inner row of racks run to the common area. There is no space between the common area and where the racks begin. There is probably about four-and-a-half feet of space between each row of racks and between the bottom and top bed of the double racks. We are packed in here.
 12. We do not sleep head to foot. Everyone sleeps however they want. No one has told us to do otherwise.
 13. It is physically impossible for all of us to maintain six feet of distance between one another, and we have not been told to try to do so.
 14. For the 100 men who live on a zone, there are seven sinks, five toilets, four urinals, and three phones. It is difficult to get a call on the phones. There is usually a line for the phones and people use them continuously during the day.
 15. When we are anywhere on the zone—the common area, living area, or bathrooms, we are never six feet apart. It is impossible to do that. No one has told us to try.
 16. There are not enough tables in dayroom area for everyone to eat—only four tables and sixteen seats at all four tables combined. I'm on my rack 90% to 95% of the time. Some guys like to play dominos or chess at the few tables. I have not seen anyone disinfecting the game pieces or parts.
 17. When the nurses come for pill call or when we go to shift command to line up for pill call, nobody lines up six feet apart. No one tells us we need to stand six feet apart.

Staff Absence

18. CMCF is very understaffed. There is usually just one guard watching us from the building's one tower. Each building of 200 people is composed of two zones of 100

men each. The building's tower sits between the two zones.

19. CMCF often has one officer split between two buildings, which together contain four zones. That means 200 people in the building are completely unsupervised, and four hundred people are unsupervised between two buildings when that one officer is between buildings or unavailable. When no tower officer is present, there is no means by which a resident can get help—there is nobody to tell and no way to get medical attention.
20. Sometimes a second staff member, often a captain or lieutenant, enters the zone but just walks up into the tower, signs a book, and leaves.
21. Staff are supposed to do counts of residents regularly, which does not happen at CMCF. Sometimes, they count only once in three days. You can't fail to notice a count. When it happens, every resident has to get and stay in their rack and another officer—monitored by the tower officer—has to come onto the zone. Counts require two staff be in the same place at the same time: one in the tower and one on the floor. CMCF doesn't appear to have enough staff for it.

Medical Conditions

22. I suffer from high blood pressure, an enlarged prostate, degenerative joint disease, a disease that effect my spine, I get boils every few months and have digestive issues, and most recently, I broke my hand badly and it has healed incorrectly. I am awaiting an appointment with an outside doctor to fix my hand.
23. I am under the care of a physician for these medical conditions, and I take prescription medication to control my blood pressure, enlarged prostate, cholesterol, and I take a blood thinner to prevent blood clots. I have had high blood pressure since about 1996, had an enlarged prostate for a couple of years, and had the disk and spine disease since about 2014 or 2015. I broke my hand in December 2019.
24. Once in a while I miss my high blood pressure medication. If I do, I get a bad headache and feel really tired, lethargic, and feel a loss of energy. My broken hand currently causes me pain. It still feels broken.
25. Because coronavirus is in prisons and I suffer from underlying medical conditions, I fear for my safety, health, and life.

Cleaning

26. Most of the people on the zone spend most of their time in the living area of the zone—the racks. There is not enough room in the common area for many people to use it at the same time.
27. We eat on our racks, sleep on our racks, and socialize from our racks. If people visit one another, they visit each other at their racks. They exchange property, papers, food, and

chat on and between the racks. All day. Even if you—like I do—try to practice as much social distancing as possible, it's not possible to stay six feet apart from others. I do not socialize with people on my zone unless absolutely necessary because I am afraid of getting sick with coronavirus. But even if you take pains not to socialize, like I do, there is so much foot traffic day and night in front my rack, it's impossible to avoid being within inches or a couple of feet of each other on pretty much an ongoing basis.

28. We are not getting any cleaning supplies of any type to clean our rack area, which makes up our living, eating, and socializing space.
29. There is a lot of movement by individuals on the zone between and among the racks. Most of the activity and interaction between residents takes place between and among the racks. All day every day you see people coughing and sneezing. A lot don't cover their mouths when they cough or sneeze and the racks are so close together, you can't help but get someone else's coughing or sneezing on you. Not many of the men use tissue to cover their coughs and sneezes because we have no facial tissue and toilet tissue is strictly rationed.
30. About once a day, prisoners are wiping down the common area and restrooms, including the phones, tables, sinks, toilets, and two microwaves, which 100 people share.
31. If residents had access to cleaning supplies to clean our living spaces, they would do so. Some residents are so desperate to keep their living spaces clean, they barter valuable property or personal food for access to cleaning supplies. This kind of trading is not possible for many people.
32. Officers share radios. I haven't personally observed them clean their radios.

Hand Hygiene

33. For people who do not have money on their books, which is the vast majority of residents, they have to use the state soap to wash their hands. I try not to use that soap because it is irritating to my skin. It makes it dry out and itch a lot. It has made other residents break out in rashes that I have seen. I believe it is lye-based soap. I buy Dial soap from canteen with the money I earn from my job. Most people cannot do this.
34. I know many residents who avoid washing their hands some or all of the time because they don't issue enough state soap and one bar of it will not last all week. When I have used the state soap in the past, it lasts just a couple of showers. If you shower every day with state soap, you won't have enough of it to wash your hands regularly. MDOC only provides state soap one time per week. Since coronavirus, MDOC provided one bar of Dial soap to the people on my zone, then about a month later provided one more bar of Dial soap.
35. A bar of Dial soap does not last more than two weeks if you use it for showers and for regular hand-washing. I avoid washing my hands to preserve my soap. I sometimes just use water. I believe this is very common for people on my zone.

36. There is no soap available in the bathroom to use when you wash your hands or take a shower. If you want to use soap, you have to bring your own bar from your rack into the bathroom, bring it into the toilet with you if you are using it, use it at the sinks, then bring it back to your rack. A lot of residents forgo using soap because you cannot always make the trip to your rack and back if you really need to use the restroom. The zones are very overcrowded, and you might not have the option to navigate the trip back to your rack and then to the bathroom if you are far from your rack when you need to use the restroom. There are also a number of people on our zone who use wheelchairs.
37. There are no paper towels provided to dry your hands after you wash them. If you want to use the bathroom, you have to bring your towel from your rack, go into the bathroom, bring your towel in with you to the toilet if you are using the toilet, bring it out, use the sinks, then use your towel. The way I can keep hold of my towel to use after hand-washing while I navigate using the toilet first is to put my towel into the waistband of my boxers. The sinks are half filthy, so most people try to avoid putting their towels on the sinks while they use the toilet.
38. There is no facial tissue. MDOC provides us one roll of toilet tissue a week that we have to use for our toilet and facial tissue needs. I have been sick before, and I have run out of toilet tissue. Toilet tissue is so scarce that people regularly trade each other for valuable items to get more toilet tissue. MDOC will not provide more if you run out.
39. You have to bring your own toilet paper into the bathroom from your rack and return it after you finish using the bathroom.
40. We do not have hand sanitizer available for common use or on commissary. Once a couple of weeks back, the warden came on the zone and said everyone who wanted a squirt of hand sanitizer could have one. That is the only time residents have been offered hand sanitizer.

Communication

41. At one time, there were a couple of memos about coronavirus posted on the bulletin board on our zone, which is near the door. I read them. They were only in English. They described procedures employees are supposed to follow and advised residents to wash our hands. About a day or so after these were posted, all of the memos about coronavirus were torn down. They do not have the staff at CMCF to monitor what is going on here. Certain groups of prisoners run the unit.
42. Besides these memos, we have not received any additional information about the coronavirus or how to reduce the risk we get it or give it to others.

Protection

43. When residents clean the common areas, they generally have on gloves. Sometimes they wear masks and sometimes not.

44. On or around April 20, 2020, we received facemasks. We were not told to wear them, and it was optional whether to take them. Staff came onto the zone and said—if anyone wants a mask, to come to the door and get one. Most residents did. Residents are not wearing their masks on the zone.
45. Recently guards have started wearing masks.
46. I have not had a flu vaccine. When I arrived here, I visited the clinic and happened to notice a posting saying that flu shots were available. It was only in English. If you didn't happen to visit the clinic during that time and didn't read or didn't read English, you would not have known flu shots were available.

Sick Call

47. Typically, if I fill out a sick call slip at CMCF, it takes multiple days to get seen.
48. I have not heard of any expedited process to be seen by medical staff if we have symptoms of coronavirus.

Grievances

49. MDOC's ARP, or grievance, process takes about 90 or more to exhaust—assuming MDOC sticks to their own policies about grievance response, which they often don't. After you fill out your ARP, you can't submit it right away. You have to first submit another request form to Inmate Legal Assistance Program (ILAP), also referred to as a "law library form," requesting that ILAP pick up your ARP. But ILAP only picks up ILAP request forms once a week. So you can have completed your ARP and still may need to wait a week to start the process. After ILAP picks up their forms, you need to wait until it's the one day of the week that ILAP summons people to the law library who have submitted forms to them. When you are called up to the law library that day, you can then give your ARP to ILAP staff in the law library. Both of these steps mean you may wait over a week to submit your completed ARP form to begin the process.
50. MDOC has 45 days to respond to your first step complaint. They do not reliably respond within this timeframe. If they don't, I have had to write them after their time runs, notify them that their time has run, and request their response. After me writing to them, I have had it take weeks past MDOC's deadline to receive a first step response. After you receive it, you have seven days to file a second step appeal if you are dissatisfied with MDOC's first step response. MDOC then has another 45 days to provide a second step response. MDOC does not reliably respond to second step appeals within the 45-day timeframe. I have had to write them after their time runs, notify them that their time has run, and request their response. After me writing them, I have had it take weeks longer past MDOC's deadline to receive a second step response. This is for correctly submitted grievances.
51. MDOC's grievance system is considered by most to be a dead end—and to have been

designed to be a dead end. ILAP is notorious for losing peoples' grievances and automatically denying legitimate requests for relief. Prisoners are in all ways discouraged from using the ARP system, including due to the complicated and time-intensive submission process, the need to prod MDOC to receive responses when they miss deadlines, and due to the extremely high likelihood of rejection for legitimate grievances.

52. I understand that there is supposed to be an emergency ARP process available. I attempted to use this very recently to address a time-sensitive medical concern about my broken hand. I did receive a response. The letter said that my concern did not create a substantial risk of serious personal injury, cause other serious or irreparable harm, or remove the attainability of the requested action. It directed me to re-file the ARP via the standard process within five days. I have, but the process will take months.
53. I have been trying for close to three weeks to file an emergency ARP about MDOC not doing what it ought to be doing to keep us safe from coronavirus. Among other things, I noted that CMCF is overcrowded, understaffed, insufficiently cleaned, that MDOC is not providing soap or cleaning supplies that we can regularly use, and that we do not have tissue or paper towels. MDOC is also not providing enough staff to help if any of us has symptoms of coronavirus and needs to see a doctor or be isolated for everyone's safety right away.
54. I completed an emergency ARP regarding the coronavirus and then submitted a request to have ILAP call me to the law library to submit my ARP to them. That is the only way to submit an ARP form. I submitted the request to ILAP on or around April 22, 2020. ILAP picked up that request form on or around April 26, 2020. I was supposed to have been called up to the law library to submit my ARP on or around April 29 or April 30, 2020. ILAP did not call me on either day. On April 30, 2020, I informed the tower officer and requested that I be allowed to go to the law library to file my emergency ARP. The tower officer called the law library and nobody there answered. I asked again and the tower officer finally got ahold of the law library. ILAP informed the officer, who informed me, that ILAP would not accept my emergency ARP about coronavirus procedures.
55. On April 30, 2020, I also received a letter via regular mail, not legal mail, from ILAP. The letter was dated April 29, 2020 and was signed by Jessica L. Jones. It said: "Due to the COVID-19 pandemic, contact is being limited between offenders and staff. If you have an ILAP deadline during this time, please indicate the time and date on your ILAP request to ensure staff can properly assist in meeting that deadline."
56. Submitting a regular or emergency APR is not an ILAP deadline. I understand from what occurred on April 30, 2020, that ARPs about the coronavirus are not being accepted by ILAP because they are not considered to have deadlines. I doubt it will help, but I am trying again. I submitted a second ILAP form the very next day, on or around May 1, 2020. That ILAP form was supposed to be picked up by ILAP on or around May 3 or 4, 2020. If ILAP calls me up at all to submit my emergency ARP, it won't be until on or around May 7, 2020, which is between two and three weeks since

my original emergency ARP about coronavirus was completed and ready to submit.

57. Attached as Exhibit 1 is a true and correct handwritten copy of the ARP I drafted on or before April 22, 2020, which I dated April 29, 2020—on or around the date I expected to be able to submit the emergency ARP to ILAP.

58. At this rate, I can't see how any relief—even if granted—could prevent me or others from getting sick or dying due to a preventable coronavirus outbreak.

Other

59. I am afraid that if I am exposed to coronavirus while detained and need help, I would become ill extremely quickly because of my medical conditions, and I would not be isolated for others' safety or be able to get help in time to survive.

60. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

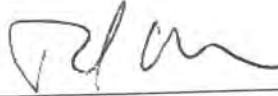
Dated: May 6, 2020

Signature:

A handwritten signature in black ink, appearing to read 'Paloma Wu', written over a horizontal line.

Paloma Wu signing for Tony Smith of Rankin County, Mississippi

Witness Signature: _____



Dated: May 6, 2020

I, Rob McDuff, am an attorney barred in Mississippi.
On May 6, 2020, I joined a phone call with Declarant Tony Smith and Attorney Paloma Wu. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the attorney to execute it by signing on the Declarant's behalf.

Decl. Exhibit 1

Emergency Request for Administrative Remedy

Legal Claims Adjudicator

CMCF

P.O. Box 88550

PEARL, MS 39288

Tory Smith # R1422

CMCF 720 B2 CORE BED 42

P.O. Box 88550

PEARL, MS 39288

April 29, 2020

RE: CORONAVIRUS PREVENTION

I AM initiating this GRIEVANCE BECAUSE VERY little is being done to ENSURE the HEALTH AND SAFETY of MDOC INMATES during this COVID-19 PANDEMIC.

It is imperative that MDOC follow CDC Guidelines for the PREVENTION AND MANAGEMENT of this VIRUS, AS the RISK for infection HAS INCREASED DRAMATICALLY. It is clear that MORE STEPS NEED to be TAKEN.

The RELIEF I AM SEEKING, is, but not limited to;

- 1) CURRENTLY, I AM HOUSED AT 720 AT CMCF, which ARE medical units AND HOUSES predominately INMATES with underlying health conditions. With that in mind, MDOC should follow CDC Guidelines for MANAGING COVID-19, including sanitizing common AREAS/buildings, providing SOAP AND TISSUE that does NOT IRRITATE the SKIN AS WELL AS cleaning supplies.

- 2) MDOC should supply liquid SOAP, PAPER towels, AND HAND SANITIZER with A NO TOUCH TRASH RECEPTOR in the BATHROOM AREA, AS WELL AS LOW COST/NO COST HAND SANITIZER for INMATE PERSONAL USE.
- 3) MDOC should provide sufficient staff to issue supplies AND to SUPERVISE CLEANING AND SANITATION to ENSURE WORK is being done properly.
- 4) MDOC should provide FREE testing of ALL INMATES AS WELL AS NO COSTS FOR SICK CALLS GERMANE to flu symptoms.
- 5) MDOC should post MEMOS listing PROCEDURAL REQUIREMENTS to be followed in multiple languages.
- 6) ISSUANCE AND the WEARING of FACE MASKS should be MANDATORY AS SOCIAL DISTANCING CANNOT be PRACTICED in the housing units.

In closing, by GRANTING my Relief, AND complying with the CDC Guidelines, MDOC will have GREATER SUCCESS in protecting the INMATE population AND staff alike. AFTER ALL, WE ARE ALL in this together. I thank you in ADVANCE for your consideration.

Respectfully Submitted,
 Jony Smith #R1422
 CMCF 720 B3 CZone BED 42
 P.O. Box 88550
 PEARL, MS 39288
 April 29, 2020

EXHIBIT 14

DECLARATION OF BRITTANY WADDELL

I, Brittany Waddell, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746:

1. I live at Central Mississippi Correctional Facility (CMCF) and have been here since January of 2020. I am 33 years old. I am in prison for a drug-related offense. I have three children.
2. I currently live in a women's unit in Building 2A, A-Zone. This is a quick bed, or reception, building. In my zone, we currently have about 120 women. To the best of my understanding, our building is composed of four identical zones: A-Zone (holding minimum and medium custody residents); B-Zone (holding close custody residents); and C and D-Zones. There are 140 beds per zone. I believe another building at CMCF that houses women, called the Yard, has three zones: A, B, and C.
3. A couple of weeks ago, an officer opened the door to the zone, yelled that we were quarantined for fourteen days, and shut the door. We weren't told anything more. Only later did we happen to learn from a guard that another guard who had been on our zone had coronavirus symptoms. We got off quarantine last week.
4. No intensified cleanings or disinfecting measures were ordered or conducted on the zone during this time or at any time since the pandemic started. Throughout, cleaning consists of the cleaning of the common area about once a day.
5. During the fourteen-day quarantine period, we had our temperature checked a total of three times.
6. During temperature checks, we were told to get on our bunks. They put a thermometer close to our heads. Sometimes the person doing it said the temperature out loud and sometimes not.
7. We were not told of any quicker way we were supposed to get seen by medical staff if we thought we had symptoms of coronavirus.
8. On quarantine, we could not go to the lunchroom. We had yard and used the same tables and yard equipment that the non-quarantined zones used. I have never seen this equipment get cleaned.
9. In February of this year, many women got sick with flu-like symptoms. I believe they were housed in A Building on the Yard and possibly also in Building 2A A-Zone. I don't know if they got flu tests or coronavirus tests.
10. The zones I have been housed on at CMCF are overcrowded. It is obvious that more beds were squeezed into the building since they were originally built.

11. In our building, a half-wall runs straight down the middle of the zone. There are two rows of bunk beds on one side of the half-wall; two rows of bunk beds on the other side of the half-wall; and two rows of bunk beds on the back wall on both sides of the half-wall. The rows of bunk beds are about three feet apart. There are two single beds, one of which is broken, that people who use wheelchairs occupy.
12. I was told the racks used to start past where the table area ends; now the racks start up front and the tables go between the racks. In other zones at CMCF that I have lived in, you can lay on your bunk and reach out and put a cup in the microwave everyone uses. In this zone, our bunks are built right up against the common room tables. My bunkmate to my side can reach out and put her cup on the seat of the table. She can't pull her bunk drawer out because it will touch the seat. We are packed in here.
13. About 80% or more of the space in the zone is taken up by racks. The common area is hemmed in by racks.
14. We do not sleep head to foot; nobody has told us to do that.
15. We have one working water fountain between the more than 100 of us. Two sinks work with water pressure; the others drizzle water. The showers include six or eight shower heads on a common water pipe. Other peoples' water splashes on you when you shower.
16. There is no way to maintain six feet of distance between us anywhere on the zone. Even if you try to avoid physical contact, there is no way to avoid it. If I try to make it to one side of the zone to the other to go to the bathroom, it's like trying to get through a herd of cattle to get to the gate. You have to walk sideways through packs of people pushing through. Especially when it is tray time, everyone is trying to get through each other.
17. The common area on our zone consists of eight tables with four stools each, so thirty-two seats for over 100 of us. When you sit at the table, your knees bump. The tables are very small. Everyone sitting at a table is sitting less than six feet apart. We have not been told to sit six feet apart.
18. Right now we are taking pill call at the tower. Nobody tells residents to line up six feet apart and nobody does. The pill call line goes down the middle of the zone. If you want to pass through the line during pill call, you will be scooting sideways in between people.
19. When we are taken to see medical staff, we are brought in large groups by a shuttle van to the reception center and placed in holding tanks together, then taken out of the holding tank one by one to see medical staff. Today, I was held in a holding tank for about forty-five minutes with ten other people waiting. The holding tank was about ten feet by ten feet, at the most, with solid walls, a solid door, no window that opens, and no ventilation. One lady in there would not stop coughing. She was taking her mask on and off. Not all of the other residents had their masks on. As I was leaving, more residents were coming from the van to go into that holding tank. The officers working

in the reception center were not wearing their masks or were wearing them on their chin.

20. Often on weekends, we don't have any guards watching us. There is a shared tower over our zone and the next zone over. Together, both zones house over 200 people. If there is an officer in the tower, there is typically only one with no additional officer on the zone.
21. People have had urgent medical needs when no officers are here to alert medical staff. When I was housed in D-Zone, there were two pregnant ladies that were 38 weeks along, and we were terrified for them.
22. In about April of this year, a pregnant lady's water broke in the bathroom on D-Zone where I lived. At that time, as often happens, the bathroom was flooded. In that zone, there are ten toilets and only four of them worked, and they leaked water constantly. People fell a lot in that bathroom. It was awful. Some other residents pulled the pregnant lady's bed into the bathroom by the toilet after her water broke because there was no staff to get medical help. It was terrifying. The only way we finally got medical staff to come help her was after all of the about one hundred women on that zone all started screaming as loud as we could and beating on the walls and banging on the windows facing the Shift Command building. Finally, someone heard us. Guard staff came into the building and wheeled her out on a wheelchair.
23. When I was housed in D-Zone, it was not uncommon to have no officers anywhere in the tower or on the zone for entire shifts. A shift is twelve hours. During those times, we assumed one officer was in the tower over Zones A and B, because an officer would pop over to our zone maybe once during an entire shift to flick off the lights.
24. We are supposed to have regular counts of residents. This only happens maybe once every two or three days. There is no pattern to when it happens and doesn't.
25. I have been diagnosed with depression and bipolar disorder. In the past, I have self-medicated to cope with the symptoms of this illness. I am currently managing without prescription medication. If I got on prescription medication here, I would be ineligible to be transferred to a satellite facility nearer to my family.
26. The common areas and bathroom are cleaned about once a day. No intensified cleaning or disinfecting has been ordered or conducted since the coronavirus pandemic began or since our unit was put on quarantine.
27. The rack areas are not cleaned. If you want to clean your rack area yourself, there are rarely any chemicals available because cleaning chemicals meant for the zone are often not used for that purpose; they are instead diverted and sold or traded for profit.
28. The state provides lye soap every week. That soap irritates my skin. The bars are very small, much smaller than regular bars of soap. We have to wash our clothes with the same soap they give us to wash our hands and bodies. If you don't have money from

the outside on your books, you would not have enough soap to keep clean from what the state provides. I have family support to buy soap from canteen, but many don't.

29. In the past two months, the state has provided one bar of Dial soap twice, about a month apart. One bar of Dial soap lasts close to two weeks.
30. We do not have paper towels or hand drying machines. I went to Shift Command once and requested paper towels. The guard denied the request.
31. We do not have facial tissue. We get one or two rolls of tissue per week. I have run out of state tissue. People try to ration their tissue to stretch it until the day of issue. It's chaos in here if the state issue is late. There are sanitary pads stopping up the toilet and toilets backing up. Women have their periods, so they use more toilet paper. If you get sick and use your toilet paper for coughing or because you get sick, you won't have toilet paper for other needs.
32. Residents do not have hand sanitizer.
33. There was a flyer posted up on the bulletin board about the coronavirus generally about a week and a half ago—when we went on quarantine. I believe it was only in English. That is the only information we have been provided.
34. Residents received face masks in about mid-April. Many residents are wearing them but some are not. We have not been ordered to wear them.
35. Some officers are wearing masks. Some are not. Many are just wearing masks on their chins.
36. One of the officers who was quarantined for fourteen days came back to work without her mask on. Residents on the zone asked her to put a mask on and she did not. She continues to not wear a mask when she is on the zone.
37. Nurses do not wear masks when they distribute medication through the tower tray slot. Nurses do wear masks when they come on the zone.
38. It is very difficult to get seen by medical staff. People have been submitting sick call slips and are not getting called up to see medical. It generally takes a few days to get seen if the issue is serious. If it is less serious, like for medication refills, it can take over a week.
39. I was present when an elderly woman, Ms. Jeannie, with extremely swollen feet put in a sick call slip and asked to see a doctor because she was feeling very ill and the fluid built up around her feet were causing her a lot of pain. I saw her feet. I have seen her twice tell the officer she needs to see a doctor. Both times she was told she can't see medical. She was in so much pain one of these times she started crying and laid down in her bed and kept crying. This happened about a week and a half ago. Today, guards came on our zone with bolt cutters to cut open her locker because she's now in the

hospital.

40. I have not read or heard that the six-dollar fee for sick call will be waived if you have a fever or symptoms of coronavirus. The six-dollar fee really dissuades people from seeking medical attention.
41. MDOC may charge you twice for seeking medical care, since you have to first go to a triage appointment, which can take a week to get, and then you are set up with a doctors' appointment, which can take another week to get. Altogether, seeking medical care can cost \$12, for both the triage nurse and the doctor appointment together. If you decline an appointment because you're not sick two or three weeks later, you can get an RVR for declining the appointment and they will still charge you for the appointment you declined.
42. I would like to submit an ARP about the lack of precautions taken to protect us from coronavirus. However, the only way to get an ARP form is to ask a guard. It is common knowledge that it's up the guard you ask whether or not to provide a resident with an ARP form. Also, many people often receive no response to their ARPs. My friend recently requested an ARP from an officer who declined to provide one. I also heard an officer make a statement to us about filing grievances that made me believe I would be retaliated against if I filed an ARP. In the past, this officer has retaliated against many people on my zone if one person files an ARP.
43. I am afraid that if I am exposed to coronavirus while detained and need help at CMCF, that I would not be able to get help in time to prevent me and others from becoming very ill or dying.
44. I have authorized an attorney to sign on my behalf because of the difficulty and risks of travel and in-person visitation during the coronavirus pandemic.

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

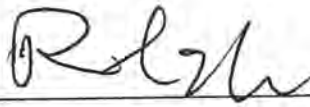
Dated: May 13, 2020

Signature:



Paloma Wu signing for Brittany Waddell of Rankin County, Mississippi

Witness Signature:



Dated: May 13, 2020

I, Rob McDuff, am an attorney barred in Mississippi.

On May 13, 2020, I joined a phone call with Declarant Brittany Waddell and the above-listed attorney, Paloma Wu. On that call, this declaration was read verbatim to the Declarant. The Declarant then verbally directed the above-listed attorney to execute it by signing on her behalf.

EXHIBIT 15



COVID-19

Questions and Answers

**Answers to some of the most frequently asked questions:
Last Update: May 21, 5 p.m.**

Q-1. What is the Mississippi Department of Corrections doing to ensure the well-being of staff and inmates?

A. The MDOC has provided masks to all inmates and correctional staff. Gloves and additional soap are provided. Hand sanitizer stations are installed in strategic locations for both staff and inmates' use. Fire and safety personnel are sanitizing all areas. Information regarding frequent hand washing, cough hygiene, and social distancing has been distributed to staff and inmates. Signs are posted in facilities. Staff and inmates are recommended to follow health guidelines from the Centers for Disease Control (CDC) and Prevention.

Inmates can access medical staff using the sick call system. A face-to-face triage is completed within 24 hours of submission of the sick call request. Medical staff are seeing inmates with acute respiratory symptoms in a timely manner. Symptomatic inmates with fever are tested according to Mississippi State Department of Health and CDC guidelines. They will be quarantined, according to MSDH and CDC guidelines. Affected patients will receive treatment and may be transferred to a community hospital, if symptoms become severe.

Security staff and non-security staff are screened daily for elevated temperature. Staff found to have a fever (temperature of 100.4 or above) will not be allowed to report to work that day and will be advised to contact their doctor's office. Staff members who are feeling ill prior to reporting for duty are urged to stay home and see their physician, if needed. A screening tool questionnaire has also been implemented for staff arriving at a correctional facility. The questions include asking about recent travel from an affected country and possible exposure to someone who has suspected or confirmed COVID-19 disease.



Q-2. How many confirmed cases are in the inmate population?

A. Twenty-one (21) cases of COVID-19 have been confirmed in the inmate population – two (2) at the Central Mississippi Correctional Facility, two (2) at the Mississippi State Penitentiary (MSP) at Parchman, three (3) at the East Mississippi Correctional Facility, three (3) at the Carroll-Montgomery County Regional Correctional Facility, nine (9) at the Marion-Walthall County Regional Correctional Facility, and two (2) at the Winston-Choctaw County Regional Correctional Facility.

Q-3. What happens in the event of a confirmed case of COVID-19 in an MDOC facility?

A. The MDOC has extensive protocols in place to address scenarios when illness is present. These include immediate quarantine and treatment at facility infirmaries, designated areas or outside hospitals as necessary. Sterilization of all surfaces also is included. Inmates in close proximity to any inmate testing positive are quarantined and receive enhanced screening in addition to wearing a mask. Quarantined inmates are monitored daily for symptoms of the coronavirus.

Q-4. In addition to the positive inmate cases, how many other inmates have been tested and what is the status of those tests?

A. The MDOC has tested 44 other inmates. Thirty-eight (38) tests show negative results and six (6) test results are pending.

Q-5. How many MDOC employees have tested positive?

A. The department has ten (10) employees to test positive for COVID-19.

Q-6. How many other employees have been tested and what is the status of those tests?

A. Fifty-two (52) other employees have tested. Forty-three (43) tests showed negative results. Nine (9) test results are pending.

Q-7. When does MDOC test inmates for COVID-19?

A. The criteria for testing inmates are the same as for the general public. Testing priorities include having a fever of 100.4 or above and symptoms of an acute respiratory illness (cough or difficulty breathing). Inmates with fever and respiratory illness are tested for influenza. If the influenza tests are negative, then the inmate is tested for COVID-19. The inmate patient will remain isolated in the infirmary until the test result is received.

Q-8. Are inmates required to pay medical co-pay during the COVID-19 pandemic?

A. No. Co-pay for any inmate sick call related to influenza or COVID-19 is waived.



Q-9. How long will the restrictions on visitation for family, friends, and volunteers continue?

A. A date for lifting restrictions has not been determined. Resuming visitation is based on current updates of the COVID-19 impact.

Q-10. If I usually travel from out of state to Mississippi to visit an inmate, how can I find out the status of the visitation suspension before I leave?

A. Call the facility first. Telephone numbers are listed on the MDOC website (www.mdod.ms.gov) or contact the Office of Communications at MDOCOfficeofCommunications@mdoc.state.ms.us

Q-11. Are inmates allowed to meet with their attorneys?

A. Yes. All legal visits are permitted. The legal visit areas are sanitized after each visit.

Q-12. How can family and friends maintain contact with their incarcerated loved ones?

A. Telephone calls through the inmate phone system will continue uninterrupted. The United States mail also is a good way to communicate with inmates.

Q-13. In addition to masks, gloves, and hand sanitizers being provided, what other steps have been taken to protect staff and inmates from potential exposure to the coronavirus?

A. Additional cleaning is occurring. Fire and safety staff are ensuring that additional chemicals are available in the housing units. Inmates are receiving antibacterial soap. The MDOC is recommending staff and inmates follow the health guidelines from the Centers for Disease Control (CDC) and Prevention. Social, distance, and hygiene protocols are being followed as well as the avoidance of unnecessary groups or meetings of ten (10) or more.

Q-14. Can inmates travel on approved leave, such as to funerals or wakes?

A. No. Movement remains suspended.

Q-15. Are prisons on lockdown because of COVID-19?

A. No. Prisons are not on lockdown.

Q-16. What activities can inmates participate in during this time? Will activities, including educational and religious programs, continue?

A. Programming remains suspended. However, inmates are free to participate in recreational activities while practicing social distancing.



Q-17. If an inmate is scheduled to be released, will the release occur?

A. Yes. All scheduled releases will occur as planned.

Q-18. Will inmates be considered for early release because of the coronavirus pandemic?

A. No. Inmates are being released through the standard release practice.

Q-19. Are inmate transfers or movement from county jails affected?

A. Yes. There are limited transfers of inmates between MDOC facilities and from county jails, unless absolutely necessary.

Q-20. Are inmates allowed to go off grounds for work assignments?

A. No. Inmate work crews remain suspended.

Q-21. Should people on community supervision, including probation/parole, continue reporting to supervising agents via email or phone?

A. Yes. The phone call will serve as their report. All calls must be made between 7 a.m. and 6 p.m. Monday through Friday. No calls will be accepted on weekends. Individuals are not required to speak with their assigned agent when they call. Individuals must provide the person answering the phone with their name, MDOC number, address, and phone number. They will be asked additional questions related to employment and other issues specifically as a result of the COVID-19 pandemic. Individuals can also email their agent or use technology portals, such as Skype and FaceTime, to communicate. Individuals will be considered non-reporting if they fail to contact the MDOC.

Community supervision also includes house arrest, earned release supervision, conditional medical release, and interstate compact, which includes movement between states.

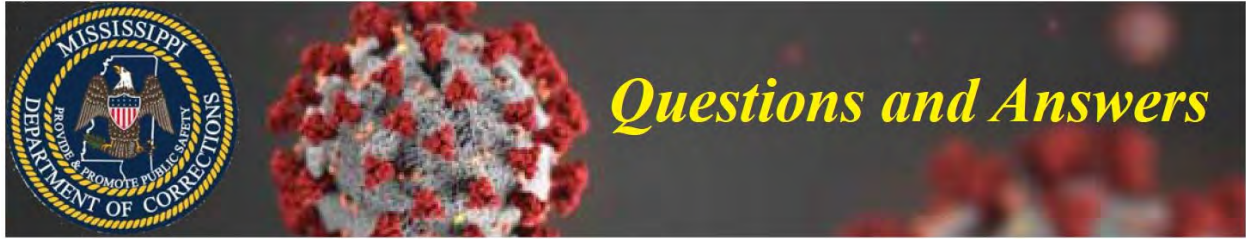
Q-22. Is out-of-state travel permitted for individuals on supervision?

A. No. Issuance of permits remains suspended until further notice.

Q-23. What is the MDOC's current COVID-19 practice regarding individuals in the Interstate Compact program, which handles the transfers between the states of individuals under supervision?

A. Mississippi is only processing incoming transfers that are resident, resident family, and military. Approvals are only for probationers living in the receiving state at the time of sentencing and those with military affiliation.

For outgoing cases, go to [interstatecompact.org](https://www.interstatecompact.org) for a list of state restrictions to see if an offender will be able to transfer to a particular state. The list changes frequently so you should check it often for the most current information.



For current information regarding the coronavirus, visit the following websites:

www.coronavirus.gov

www.cdc.gov/COVID19

<https://msdh.ms.gov>

**The Mississippi Coronavirus Hotline is available 8 a.m. until 5 p.m. Monday-Friday
Call **877-978-6453****