IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*,

Plaintiffs,

v.

DISTRICT OF COLUMBIA, *et al.*,

Defendants.

Case No. 1:19-cv-3185 (RDM)

PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER

Plaintiffs, by and through counsel, and pursuant to Rule 65 of the Federal Rules of Civil Procedure, Local Rules 7 and 65.1, and the Court's April 17, 2020 Minute Order, hereby move for a temporary restraining order. A statement of points and authorities is support of the motion and a proposed order accompanies this motion.

Dated: April 18, 2020

Respectfully submitted,

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CERTIFICATE OF COUNSEL

Pursuant to Local Rule 65.1(a), counsel hereby certifies that actual notice of the application for a temporary restraining order and copies of all pleadings and papers filed in the action to date and in support of this application have been furnished to opposing counsel via the ECF system at or before 12:00 noon on April 18, 2020, and that actual notice of the time of making the application has been provided to all parties by the Court via minute order of 5:17 pm on April 17, 2020.

Pursuant to Local Rule 65.1(b), counsel hereby certifies that this application has been filed outside business hours pursuant to the discussion at the April 17, 2020 hearing and the Court's April 17, 2020 minute order.

/s/ John A. Freedman
John A. Freedman

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PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR A TEMPORARY RESTRAINING ORDER

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INTRODUCTION

This motion reflects the latest chapter in a continuing saga characterized by Defendants' abject failure to protect the health of the patients entrusted to its care at Saint Elizabeths Hospital in light of recognized, life-threatening dangers. Initially, Plaintiffs filed a Complaint to remedy Defendants' failure to have in place an adequate emergency plan — a failure that interrupted the medical care of Plaintiffs and other patients at Saint Elizabeths and placed these patients at risk by forcing them to live in unsanitary conditions without running water for 28 days after Defendants discovered that the water supply was contaminated with legionella and other bacteria. Now, Defendants' persistent apathy toward emergency planning has caused the rapid and deadly spread of COVID-19 among the patients and staff at Saint Elizabeths, already resulting in four deaths and dozens of confirmed infections.

To curb this escalating danger, Plaintiffs seek a temporary restraining order requiring Defendants to take immediate steps, as set forth below, to ensure that patients are appropriately protected and, where possible, released or moved to places where they may continue to receive medical care in a safer and healthier environment.

As of April 16, 2020, at least 33 individuals in the care of Saint Elizabeths Hospital, as well as at least 51 of the hospital's staff, have tested positive for COVID-19.[1] Four have died. And a far greater number of individuals are symptomatic – 74 patients are currently in isolation or quarantine due to exposure or symptoms, and 82 staff are out related to the virus.[2] This is remarkable given that the District reported the first COVID-19 cases at St. Elizabeths on just April 1.[3] Like other "congregate" environments where people live, eat, and sleep closely together (*e.g.*,

[1] Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data
[2] *Id.*
[3] *Id.*

ships, nursing facilities, correctional facilities), the virus's exponential spread through Saint Elizabeths appears to be even faster than the spread that is happening locally, nationally, and around the globe. The virus appears to be spreading fastest in correctional facilities like Rikers' Island in New York and Cook County jail in Illinois. Indeed, as of April 15, 2020, the District of Columbia has reported 2,058 cases of COVID-19 and at least 67 deaths; the number of cases is doubling approximately every six days.[4]

The methods for containing the contagion have been well-publicized. The Centers for Disease Control and Prevention ("CDC") and other public health experts have advised that the best method to limit transmission of the virus is to avoid gatherings, practice "social distancing" (a minimum of six feet between people), engage in meticulous personal hygiene, expand screening and testing, isolate symptomatic and exposed individuals, and quarantine of known cases. For individuals in facilities like Saint Elizabeths, the CDC further recommends that if the "facility cannot fully implement all recommended precautions" residents with "known or suspected COVID-19 . . . should be transferred to another facility that is capable of implementation"[5] In accordance with that guidance, and in response to the increasing numbers of confirmed cases of COVID-19 in Washington, D.C., Mayor Bowser has issued a series of executive orders that carry the force of law and include criminal penalties for those who do not follow these basic public health practices. The Mayor's orders relied, in part, on the following findings:

> This Order is issued based on the increasing number of confirmed cases of COVID-19 within Washington, DC, and throughout the metropolitan Washington region.

[4]As of April 13, 2020, there were 554,704 cases and almost 22,000 deaths attributable to COVID-19 reported in the United States, and more than 1,773,084 people have been diagnosed with COVID-19 in 213 countries or territories around the world and 111,652 have died as a result. Centers for Disease Control & Prevention ("CDC"), "Coronavirus Disease 2019 ('COVID-19'): Cases in U.S.," https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last accessed Apr. 14, 2020); WHO Website

[5] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html.

> Scientific evidence and public health practices show that the most effective approach to slowing the community transmission of communicable diseases like COVID-19 is through limiting public activities and engaging in social distancing. . .. Medical and public health experts agree that COVID-19 is easily transmitted and it is essential that its spread be slowed to protect the ability of public and private health care providers to handle the expected influx of ill patients and safeguard public health and safety. . .. Because of the risk of the rapid spread of the virus, and the need to protect all members of Washington, DC, and the region, especially residents most vulnerable to the virus, and local health care providers and emergency first responders, this Order requires the temporary closure of the on-site operation of all non-essential businesses and implements a prohibition on large gatherings.

In response to the burgeoning crisis at Saint Elizabeths, on April 15, Mayor Bowser issued Order 2020-063, which requires health care facilities, including Saint Elizabeths Hospital, to take certain steps to manage the COVID-19 pandemic.[6] The Order details steps the facility must take to, among other things, maintain social distancing among residents, restrict visitors from entering the facility, manage symptomatic staff, quarantine or isolate symptomatic or exposed patients, and develop a continuity of operations plan.[7] To date, Defendants have come woefully short of performing these steps.

Contrary to District of Columbia policy and despite CDC and D.C. Department of Health guidance, Defendants have failed to protect D.C. residents most vulnerable to the virus. Medical and mental health professionals have consistently urged that individuals with mental disorders require "priority attention" in this kind of emergency.[8] Members of the proposed class, some of whom suffer from psychiatric conditions such as schizophrenia, often have compromised

[6] Extensions of Public Emergency and Public Health Emergency and Measures to Protect Vulnerable Populations During the Covid-19 Public Health Emergency, D.C. M. O. 2020-063, D.C. Reg Vol 67, 16 (April 15, 2020).
[7] *Id.*
[8] CTRS. DISEASE CONTROL & PREVENTION, Office of Public Health Preparedness and Response, *Public Health Workbook: To Define, Locate, and Reach Special, Vulnerable, and At-risk Populations in an Emergency*, at 6 https://emergency.cdc.gov/workbook/pdf/ph_workbookfinal.pdf (last accessed Apr. 14, 2020).

immunity. In particular, "mental health disorders can increase the risk of infections, including pneumonia"—a leading cause of hospitalization and death among those infected with COVID-19.[9]

In addition, because of its failure to plan, St. Elizabeths patients are not receiving the psychiatric care and treatment that is the reason they are confined to the Hospital. This has short- and long-term implications for their mental health and the conditions may be traumatic for some. The hazard of further institutionalization combined with the lack of treatment, weighs heavily against the further detention of patients who can safely be placed in community settings with appropriate supports.

There are practical remedies that can address the Defendants' failure to protect the constitutional and statutory rights of the Plaintiffs:

- Conduct an individualized assessment of each patient to assess (i) the current effect of these conditions on the patient, (ii) to determine whether other options exist in lieu of continued placement at St. Elizabeths, including community placement, and (iii) whether changes to a patient's treatment plans are needed.

- Cease all admissions to the Hospital until the density at St. Elizabeths is sufficiently reduced to allow for social distancing and patients at the hospital are no longer at a heightened risk due to COVID-19;

- Provide appropriate COVID-19 intervention and care at the Hospital, including (i) evaluating patients and where appropriate administering rapid COVID-19 tests; (ii) ensuring clinically effective isolation and quarantine for patients with confirmed and suspected COVID-19 cases; and (iii) determining equipment needs and immediately providing masks for any individuals displaying or reporting COVID-19 symptoms or exposure until they can be evaluated by a qualified medical professional or placed in quarantine;

- Ensure that each patient has timely and complete access to essential hygiene, including soap, hand sanitizer, and running water, and materials needed to disinfect surfaces that may be contaminated;

- Develop capacity for patients, who are not infected and for whom release is not possible, to be housed in an auxiliary facility until the density at St. Elizabeths is

[9] Hao Yao, et al., *Patients with mental health disorders in the COVID-19 epidemic*, The Lancet, Vol. 7, Issue 4, at e21 (Apr. 1, 2020), https://doi.org/10.1016/S2215-0366(20)30090-0.

sufficiently reduced to allow for social distancing, and implement social distancing in accordance with public health guidelines.

- Ensure robust education about COVID-19 for patients, including education about how to identify symptoms, how to take preventative measures, how to contact patient advocates, and about any changes in policies and practices at the Hospital. There should be sufficient opportunity to ask and receive answers to questions.

These are all measures that public and mental health experts say Saint Elizabeths can and should implement. If the Hospital fails to do so, this Court should order they be performed. Such action, voluntarily or otherwise, will protect this critically vulnerable population and save lives.

STATEMENT OF FACTS

1. Saint Elizabeths Hospital and its Patients

Saint Elizabeths Hospital is the District's public psychiatric facility and serves individuals with mental illness who need intensive inpatient care. FAC ¶¶ 25, 30. Saint Elizabeths is the District's only public psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care to support their recovery. FAC ¶¶ 25, 30; Ex. 1 Declaration of Elizabeth Jones ("Jones Decl.") ¶ 7. Saint Elizabeths also provides mental health evaluations and care to patients committed by the courts. FAC ¶¶ 25, 30. Patients at Saint Elizabeths Hospital are entitled to a dignified, respectful and supportive environment and generally accepted standards of individualized treatment, continuity of care, professionalism, and health and safety. FAC ¶ 31; Jones Decl. ¶ 8. Those goals must be achieved through hospital settings that are safe, calm, predictable (in terms of the patient's routine), and responsive to the needs of each individual patient. Jones Decl. ¶ 9. Where these conditions do not exist, there is a risk of further traumatizing patients and exacerbating their psychiatric conditions. Jones Decl. ¶ 10.

Saint Elizabeths has an average patient population of 270 and approximately 700 employees. FAC ¶ 32. On April 14, 2020, the patient population was 237. FAC ¶ 32. Saint Elizabeths Hospital patients are committed to the care of the District. Patients may be committed in one of several ways. Patients may have civil legal status, meaning that they are committed voluntarily, or civilly committed, or committed on an emergency basis. Patients may be committed after being adjudicated in criminal court as not guilty by reason of insanity ("NGI"). Patients may be committed to Saint Elizabeth's for forensic reasons, because they are awaiting a hearing to determine their competency to stand trial or to have their competency restored. Patients in any category may be transferred from D.C. correctional facilities or other area hospitals. FAC ¶ 34. Defendants have the authority to (i) release any patients who are civilly committed or who are committed to the Hospital voluntarily, and (ii) evaluate and recommend release or continued commitment for patients who are criminally committed or who are committed because of their NGI status. FAC ¶¶ 23-36. Saint Elizabeths Hospital patients are housed in one of 11 units, or houses. FAC ¶ 33. The units consist of bedrooms and common spaces.[10] FAC ¶ 33. Houses are organized into three clusters: admissions, continuing care and geri-medical. Some of the bedrooms are single occupancy and some are double occupancy. FAC ¶ 33.

2. The 2020 COVID-19 Pandemic

COVID-19 is the disease caused by the SARS-CoV-2 virus that has caused a global pandemic. FAC ¶ 37. The CDC estimates that as of April 15, 2020, there are 605,390 confirmed cases and 24,282 confirmed deaths in all 50 states, the District of Columbia, Guam, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands.[11] COVID-19 is highly contagious.

[10] District of Columbia Dep't of Behavioral Health Policy "Individual's Admission and Discharge," Policy No. 100.00.
[11] CTRS. DISEASE CONTROL & PREVENTION, *Cases in U.S.*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. (last visited Apr. 16, 2020).

FAC ¶ 39; Ex. 2, Declaration of Dr. Marc Stern, M.D., M.P.H. ("Stern Decl.") ¶ 8; Ex. 3, Declaration of Dr. Johnathan L. Golob, M.D. ("Golob Decl.") ¶ 6. It is thought to survive for three hours in the air in droplet form that can be inhaled, or it can be transferred to surfaces, where it can survive for up to twenty-four hours on cardboard, and up to two to three days on plastic and steel. FAC ¶ 39. [12] Due to the highly contagious nature of COVID-19, data and statistical modeling show that absent intervention, the rate of COVID-19 infections has grown exponentially. FAC ¶ 40; Golob Decl. ¶ 2. [13] People in all age brackets are at risk of serious illness and death from COVID-19. FAC ¶ 41; Stern Decl. ¶ 14 ("[I]t is becoming clear that younger individuals are not protected from severe complications requiring hospitalization and placement in intensive care."); Golob Decl. ¶ 3. [14] Although only about "one person in six becomes seriously ill" from COVID-19, the virus causes excruciating pain to those who become seriously ill. *See* Golob Decl. ¶ 4.[15] One respiratory physician explained that the lungs "become filled with inflammatory material" and "are unable to get enough oxygen to the bloodstream." FAC ¶ 42.[16] The virus leads to acute respiratory distress syndrome, in which fluid displaces the air in the lungs. The sensation of that illness is akin to being drowned. FAC ¶ 43.[17] In more serious forms, the individual can experience excruciating pain, days or weeks of fever and chills, uncontrollable diarrhea and inability to keep

[12] Neeltje van Doremalen et al., Correspondence, *Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1*, New Eng. J. Med. (Mar. 17, 2020), https://www.nejm.org/doi/full/10.1056/NEJMc2004973.
[13] Kenneth Chang, *A Different Way to Chart the Spread of Coronavirus*, N.Y. TIMES (Mar. 20, 2020), https://www.nytimes.com/2020/03/20/health/coronavirus-data-logarithm-chart.html ("Unconstrained, the coronavirus spreads exponentially, the caseload doubling at a steady rate.").
[14] CTRS. DISEASE CONTROL & PREVENTION, *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* tbl. (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.
[15] Graham Readfern, *What happens to people's lungs when they get coronavirus?*, GUARDIAN (Apr. 14, 2020), https://www.theguardian.com/world/2020/apr/15/what-happens-to-your-lungs-with-coronavirus-covid-19.

[16] *Id.*
[17] Lizzie Presser, *A Medical Worker Describes Terrifying Lung Failure From COVID-19 — Even in His Young Patients*, PROPUBLICA, March 21, 2020, available at https://www.propublica.org/article/a-medical-worker-describes--terrifying-lung-failure-from-covid19-even-in-his-young-patients.

down food or water, and extremely labored breathing requiring oxygen therapy. FAC ¶ 43; Golob Decl. ¶ 5.[18] The most severe forms require hospitalization and often artificial ventilation to preserve life. Golob Decl. ¶ 5. The artificial ventilation process is highly invasive and many who have undergone the process describe it as psychologically traumatic. Some patients are placed in medically induced comas for such treatment. Some do not survive. FAC ¶ 43. [19]

Emerging medical research also demonstrates that, in addition to the short-term risk of death posed by COVID-19, contracting the virus can lead to other serious long-term medical conditions, including cardiovascular disease and permanent reduction of lung function. FAC ¶ 44; Golob Decl. ¶ 9.[20] Because of these short-term and long-term dangers, treating COVID-19 requires a team of health care providers, including nurses, respiratory therapists, and intensive care physicians. FAC ¶ 45; Golob Decl. ¶ 8. [21] As of April 10, 2020, the available data from the CDC to date shows that, in total, 20.7 to 31.4 percent of people who tested positive for COVID-19 require hospitalization, 4.9 to 11.5 percent require admission to the ICU, and 1.8 to 3.4 percent die. FAC ¶ 46.[22] The CDC estimates that the COVID-19 mortality rate in the United States was 6.9 percent during week 14 (ending April 4, 2020) of the outbreak in the United States. FAC ¶ 47.[23] By

[18] Leah Groth, *Is Diarrhea a Symptom of COVID-19? New Study Says Digestive Issues May Be Common With Coronavirus*, HEALTH (Mar. 20, 2020), https://www.health.com/condition/infectious-diseases/coronavirus/is-diarrhea-a-symptom-of-covid-19.
[19] Katie Blocker, *Grateful to be alive: Ernesto Castro lives to tell his story about surviving COVID-19*, UCHEALTH TODAY (Apr. 1, 2020), https://www.uchealth.org/today/grateful-to-be-alive-after-covid-19-ernesto-castro-lives-to-tell-story-about-life-on-a-ventilator/.
[20] Tian-Yuan Xiong et al., *Coronaviruses and the Cardiovascular System: Acute and Long-Term Implications*, EURO. HEART J., 231 (2020).
[21] Pauline W. Chen, *The Calculus of Coronavirus Care*, N.Y. TIMES (Mar. 20, 2020), https://www.nytimes.com/2020/03/20/well/live/coronavirus-covid-doctor-nurse-shortage-staff.html.
[22] *Id.*
[23] CTRS. DISEASE CONTROL & PREVENTION, *CovidView: A Weekly Surveillance Study of U.S. COVID-19, Mortality*, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html#mortality (last visited Apr. 16, 2020).

comparison, the mortality rate of seasonal influenza is well below 0.1 percent. FAC ¶ 47; *see also* Golob Decl. ¶ 4. [24] There is no vaccine to prevent COVID-19. FAC ¶ 48; Golob Decl. ¶ 10.[25]

3. Risk of Infection at Saint Elizabeths Hospital

Medical and mental health professionals have consistently urged that individuals with mental health disorders require "priority attention" in this kind of emergency. FAC ¶ 49; Golob Decl. ¶ 14. Mental health disorders like those experienced by Plaintiffs can increase the risk of infections, including pneumonia, a leading cause of hospitalization and death among those infected with COVID-19. FAC ¶ 50.[26] Congregate settings like Saint Elizabeths Hospital enable and facilitate the rapid spread of COVID-19 infection. FAC ¶ 51; Stern Decl. ¶ 13; Golob Decl. ¶ 13. People live, eat, and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. FAC ¶ 51. Stern Decl. ¶ 13. This therefore presents an increased danger for the spread of COVID-19 once it has been introduced into the facility. FAC ¶ 51; Stern Decl. ¶ 13; Golob Decl. ¶ 13.

To the extent that patients are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, the risks of spread are greatly, if not exponentially, increased. FAC ¶ 52; Stern Decl. ¶ 12; Golob Decl. ¶ 14. Because people — including staff and contractors —constantly cycle in and out of Saint Elizabeths Hospitals facilities and new patients are being admitted, there is an ever-present risk that new carriers will bring the virus into the facility. FAC ¶ 53; Golob Decl. ¶ 14 (describing the same risks in other congregate settings such as prisons, jails, or immigration detention centers); *see also* Ex. 4, Declaration of

[24] WORLD HEALTH ORG, CORONAVIRUS DISEASE 2019 (COVID-19) SITUATION REPORT-46 p. 2 (2020).
[25] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2020: How to Protect Yourself and Others*, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (last visited Apr. 16, 2020).
[26] *See* Hao Yao, et al., *Patients with mental health disorders in the COVID-19 epidemic*, The Lancet, Vol. 7 Issue 4 at e21 (Apr. 1, 2020), *available at* https://doi.org/10.1016/S2215-0366(20)30090-0.div.

Hadley Truettner ("Truettner Decl.") ¶¶ 3-5 (noting that as of April 13, 2020, Saint Elizabeths is still accepting new patients). The spread of COVID-19 at St. Elizabeths Hospital could have a devastating impact on public health far beyond the Hospital's walls. Staff who enter and leave the facility could transmit the virus to the broader community and demands for intensive care beds and ventilators could overwhelm local hospitals and health care providers. It is essential at this time that all steps be taken to reduce infection and to "flatten the curve" to ensure that our health care system does not collapse. FAC ¶ 54; Stern Decl. ¶¶ 14-17.

Nursing facilities are similar congregate settings. In Maryland, Gov. Larry Hogan is sending "strike teams" to nursing facilities that are at high-risk of COVID-19 because of the heightened danger to residents. These strike teams will administer rapid tests; ensure isolation of suspected COVID-19 cases and quarantine of confirmed COVID-19 cases; determine equipment needs; and provide on-site care and medical assessment.[27] Maryland's response underscores the public and individual health imperatives for immediate and decisive action for persons confined to congregate settings and provides a model for implementing such protective actions. FAC ¶ 55.

4. The COVID-19 Outbreak at Saint Elizabeths Hospital

Plaintiffs' counsel wrote to Defendants and Defendants' counsel on March 13 and March 17, 2020 inquiring whether any protocols had been implemented to protect patients from COVID-19, urging Defendants to take immediate steps to reduce the patient population at the Hospital, and advocating for every patient to be evaluated for community placement as soon as possible. FAC ¶ 58. On March 18, they received a response stating that Saint Elizabeths implemented its Emergency Preparedness Plan ("EPP") on March 12, 2020. Defendants did not provide a copy of

[27] Editorial Board, *Nursing homes are in the pandemic's crosshairs. They can't be neglected*. WASHINGTON POST (Apr. 13, 2020), https://www.washingtonpost.com/opinions/nursing-homes-are-in-the-pandemics-crosshairs-they-cant-be-neglected/2020/04/13/7341919a-7db0-11ea-a3ee-13e1ae0a3571_story.html

the EPP or address or Plaintiffs' request to reduce the patient population. The response stated that no cases of COVID-19 had been detected among the patients or staff. FAC ¶ 61-63. Since then, circumstances have changed dramatically.

On April 1, 2020, one patient and five staff members at St. Elizabeths were confirmed to be COVID-19 positive.[28] On April 2, Plaintiffs sent a follow-up letter to Defendants requesting an update and information about Defendants' response and reiterating the request that Defendants evaluate every patient for community placement and take aggressive steps to protect patients who remain in the Hospital. FAC ¶ 64. On April 9, Plaintiffs sent a further follow-up letter. Defendants acknowledged receipt but had not otherwise responded to either letter prior to the filing of the amended complaint. FAC ¶ 64. Not until April 16 — moments after Plaintiffs filed their Motion for an Emergency Hearing and for Leave to File an Amended Complaint (ECF No. 36) — did Defendants finally respond to Plaintiffs' April 2 and April 9 letters.[29]

As of April 16, 2020, at least 33 Saint Elizabeths patients, as well as at least 51 of the hospital's staff, had tested positive for COVID-19.[30] At least four Saint Elizabeths Hospital patients have died after contracting COVID-19.[31]

5. Conditions at Saint Elizabeths Hospital

a. Social Distancing and Distribution of Masks

When there has been an outbreak of COVID-19 in the community surrounding a facility, but not yet in the facility, the CDC recommends, among other things, that the facility should

[28] Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data (last accessed Apr. 17, 2020).
[29] Following the meet and confer regarding the filing of the amended complaint on April 16, the DBH General Counsel responded, summarizing measures adopted (many of which were previously reported in Defendant Barzon's March 18 letter), confirming that the Hospital has admitted new patients since the crisis started, and reporting that 40 patients had been discharged.
[30] Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data (last accessed Apr. 17, 2020).
[31] *Id.*

implement practices to prevent and control the spread of the virus, including canceling communal dining and all other group activities. FAC ¶ 69.[32] The CDC guidance also recommends that "symptomatic residents should wear a facemask (if tolerated) and be separated from others."[33] When there are cases in the facility, the CDC further recommends that the facility should implement universal use of facemasks for health care professionals, and encourage patients to remain in their rooms, and encourage patients to wear face masks and perform social distancing when they leave their rooms by staying six feet away from others. FAC ¶ 70.[34]

Plaintiffs report that it is impossible for patients at Saint Elizabeth to maintain six feet of distance between themselves and other people in the Hospital. FAC ¶ 78, 82, 85, 89; Ex. 5, Declaration of Enzo Costa ("Costa Decl.") ¶ 4; Ex.6, Declaration of Williams Dunbar ("Dunbar Decl.") ¶ 5; Ex. 7, Declaration of Vinita Smith ("Smith Decl.") ¶ 6. Ms. Smith reports her unit is still using the same common spaces, including the dining hall, lounge area and laundry room, and are sharing furniture and facilities, Smith Decl. ¶ 5, and Mr. Costa and Mr. Dunbar report that members of their units are all still using common spaces. FAC ¶ 82, 85, 89; 94; Costa Decl. ¶ 4; Dunbar Decl. ¶ 5b. Other patients report the same. *See* Ex. 8, Declaration of Ashley Guzman ("Guzman Decl.") ¶ 3b; Ex. 9, Declaration of Wanda Rose ("Rose Decl.") ¶ 5; Ex. 10, Declaration of Danielle Mason ("Mason Decl.") ¶ 4a-b.

Defendants have not provided masks to all patients or instructed or required patients to wear masks in a manner consistent with public health guidelines. FAC ¶ 79, 83, 87, 91, 95; Costa

[32] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html
[33] *Id.*
[34] *Id.*

Decl. ¶ 7; Dunbar Decl. ¶ 5d; Smith Decl. ¶ 9; Guzman Decl. ¶ 3b-c; Rose Decl. ¶ 5; Mason Decl. ¶ 4a.

b. Screening and Testing

Patients are not being tested for COVID-19, even when they display characteristic symptoms of the virus. FAC ¶ 96, 103, 108. Such practices (or lack thereof) directly contravene CDC guidelines issued for "congregate" settings similar to St. Elizabeths; CDC guidelines for correctional/detention facilities,[35] long-term care facilities/ nursing facilities,[36] and cruise ships[37] all recommend some form of screening and/or testing for both symptomatic and asymptomatic persons. *See* Stern Decl. ¶ 16c ("Authorities must be required to screen each employee or other person entering the facility *every day* to [*sic*] according to current CDC or local health department guidelines.").

There is no COVID-19 testing taking place on-site at the Hospital. FAC ¶ 96; Smith Decl. ¶ 11; Costa Decl. ¶ 13; Dunbar Decl. ¶ 8. Some (but not all) patients are only being tested for COVID-19 (off site) once they exhibit symptoms. FAC ¶ 96, 103; Ex. 11, Declaration of Penelope Donkar ("Donkar Decl.") ¶ 3a. But patients who have been exposed to the virus but are asymptomatic are not being tested. FAC ¶ 96, 103, 108; *see* Dunbar Decl. ¶¶ 5b, 6; Guzman Decl. ¶¶ 5b-c.

[35] CTRS. DISEASE CONTROL & PREVENTION, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
[36] CTRS. DISEASE CONTROL & PREVENTION, *COVID-19 Long-Term Care Facility Guidance* (Apr. 2, 2020), *available at* https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf.
[37] CTRS. DISEASE CONTROL & PREVENTION, *CDC's role in helping cruise ship travelers during the COVID-19 pandemic* (Apr. 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/travelers/cruise-ship/what-cdc-is-doing.html.

c. Medical Isolation and Quarantine Procedures

When there has been an outbreak of COVID-19 in the community surrounding the facility, but not yet in the facility, the CDC recommends that residents with suspected COVID-19 should be isolated by being placed in a private room with their own bathroom, and that if the "facility cannot fully implement all recommended precautions" residents with "known or suspected COVID-19 . . . should be transferred to another facility that is capable of implementation" and that "while awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others." FAC. ¶ 69. When there are cases in the facility, the CDC recommends grouping ill residents with dedicated health care professionals. FAC. ¶ 70.[38]

Saint Elizabeths has established one unit with seven beds to quarantine COVID-19 positive patients. FAC ¶ 100; Guzman Decl. ¶ 3a. But there are 33 reported cases at the hospital, so it appears—consistent with the firsthand reports—that Defendants are not segregating all of the patients who are COVID-19 positive from other patients at the Hospital. Patients who have tested positive for COVID-19 are housed in close quarters and share common areas with patients who are showing no symptoms. FAC ¶ 97-99, 104, 106-107; Dunbar Decl. ¶ 5b; Donkar Decl. ¶ 4.

d. Visitor and New Patient Procedures

According to Defendants, Saint Elizabeths Hosptial has accepted five new patients since the declaration of the emergency, and there is the potential for new people to be introduced to the Saint Elizabeths ecosystem every day. FAC ¶ 132; see Truettner Decl. ¶¶ 3-5. Indeed, Saint Elizabeths is still accepting new patients from area hospitals. Truettner Decl. ¶¶ 3-5.

[38] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities,* https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html

e. Psychiatric treatment during the outbreak

There has been severe curtailment of mental health care. Patients are not receiving the same or functionally equivalent mental health care that they received prior to the COVID-19 pandemic. FAC ¶ 109-110; Smith Decl. ¶ 10; Costa Decl. ¶ 9; Dunbar Decl. ¶ 7.

Defendants have closed the Treatment Mall, suspended group therapy, suspended anger management classes and most competency restoration classes. FAC ¶ 110; Smith Decl. ¶ 10; Costa Decl. ¶ 9; Dunbar Decl. ¶ 7. Defendants have not taken adequate steps to compensate of the loss of group therapy or necessary classes or provided alternative or modified treatment plans, for example by using teletherapy or virtual therapy. FAC ¶ 111.

Mr. Costa and Mr. Dunbar normally receive group therapy. Neither of them has received group therapy or a telephonic or other remote substitute for group therapy over the past few weeks. FAC ¶ 112; Costa Decl. ¶ 9. Dunbar Decl. ¶ 7.

Mr. Costa normally also receives individual therapy, but has not received individual therapy or a telephonic or other remote substitute since Defendants ordered him to remain on his Unit. FAC ¶¶ 113, 115; Costa Decl. ¶ 10.

According to mental health experts, the failure to provide safe, secure, predictable, and continuity of care is counter to effective treatment and can result in actual harm, including regression, loss of self-esteem, exacerbation of distress and heightened instability. This can lead to longer lengths of hospitalization and likelihood of more restrictive measures, such as loss of privileges, and the use of seclusion and/or restraints. Jones ¶ 12.

6. Failure of Emergency Planning/Procedures

a. Transfers back and forth to area hospitals

When patients are suspected of having COVID-19, they are inconsistently being transferred to area hospitals for testing and for treatment. *See* Donkar Decl. ¶¶ 3a, 3c & 4. Defendants are failing to ensure that patients are properly supervised at receiving hospitals and are not effectively communicating with receiving hospitals, guardians, or counsel regarding patients in Defendants' care. Donkar Decl. ¶¶ 3a, 3b & 3c.

b. Staff absences

There are approximately 700 staff members at Saint Elizabeths Hospital. Large numbers of staff are not reporting to work. FAC ¶ 117. The DBH reported 71 staff absences caused by COVID-19 quarantine or isolation on April 15.[39]

ARGUMENT

To obtain a temporary restraining order or a preliminary injunction, the moving party must establish that: (1) it is likely to succeed on the merits; (2) it is likely to suffer irreparable harm in the absence of preliminary relief; (3) that the balance of equities tips in its favor; and (4) that an injunction is in the public interest. *Gordon v. Holder*, 632 F.3d 722, 724 (D.C. Cir. 2011) (citing *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 20 (2008)). Courts in this Circuit have traditionally applied these factors on a "sliding scale," where a stronger showing on some factors can compensate for a weaker showing on others. *See, e.g.*, *Davenport v. Int'l Brotherhood of Teamsters*, 166 F.3d 356, 360 (D.C. Cir. 1999). The Circuit has suggested, but not decided, that an independent showing of likelihood of success is required. *See Sherley v. Sebelius*, 644 F.3d 388, 392-93 (D.C. Cir. 2011) (citing *Winter*, 555 U.S. at 20-22). Under either approach, Plaintiff makes

[39]Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data

the necessary showing here. Standards for issuing a temporary restraining order and a preliminary injunction are the same and can therefore be analyzed together. *Singh v. Carter*, 168 F. Supp. 3d 216, 223 (D.D.C. 2016).

And the Court has authority to order relief to remedy unconstitutional conditions, including by release. The writ of habeas corpus, which "cuts through all forms and goes to the very tissue of the structure," *Chatman-Bey v. Thornburgh*, 864 F.2d 804, 807 (D.C. Cir. 1988) (en banc), is flexible enough to provide both authority for release and also to order remedies for unconstitutional conditions of confinement, as "[h]abeas corpus tests not only the fact but also the form of detention." *Aamer v. Obama*, 742 F.3d 1023, 1033 (D.C. Cir. 2014) (quoting *Hudson v. Hardy*, 424 F.2d 854 (D.C. Cir. 1970) (internal quotation marks omitted). The court's remedial authority in an ordinary civil action under 42 U.S.C. § 1983 is likewise broad. As the Court has long recognized in § 1983 conditions cases, "Once invoked, the scope of a district court's equitable powers ... is broad, for breadth and flexibility are inherent in equitable remedies." *Hutto v. Finney*, 437 U.S. 678, 687 n.9 (1978) (quoting *Milliken v. Bradley*, 433 U.S. 267, 281 (1977), in turn quoting *Swann v. Charlotte-Mecklenburg Bd. of Ed.*, 402 U.S. 1, 15 (1971)); *accord Citizens for Responsibility & Ethics in Washington v. U.S. Dep't of Justice*, 846 F.3d 1235, 1241–42 (D.C. Cir. 2017) (reiterating this principle).

Finally, as to discrimination against individuals with disabilities, the Americans with Disabilities Act (ADA) grants broad remedial authority to the courts. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The unjustified institutional isolation of persons with mental disabilities is properly regarded as discrimination

based on disability, for (1) in findings applicable to the entire ADA, Congress explicitly identified unjustified segregation of persons with disabilities as a form of discrimination (42 U.S.C. §v 12101(a)(2), 12101(a)(5)); and (2) recognition of such a rule reflects the evident judgments that (a) institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, and (b) confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. *Olmstead v. L. C. by Zimring*, 527 U.S. 581 (1999). The court has additionally held that public entities violate the ADA when they "care for a mentally…disabled individual in [facility] notwithstanding, with reasonable modifications to its policies and procedures, it could care for that individual in the community. *Brown v. District of Columbia*, 928 F.3d 1070, 1073 (D.C. Cir. 2019).

1. Plaintiffs Are Likely to Succeed on the Merits of Their Claim

Plaintiffs and proposed class members are substantially likely to prevail on the merits of their claims. Under the due process clause of the Fifth Amendment, "[p]retrial detainees (unlike convicted prisoners) cannot be punished at all." *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2475 (2015); *accord Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979). Pretrial detainees can demonstrate that they have been "punished" if the actions taken against them are either motivated by an intent to punish, *Kingsley*, 135 S. Ct. at 2473, or are objectively unreasonable, *see id.*

Comparably, when a government entity involuntarily commits a person, "the Constitution imposes upon [the state] a corresponding duty to assume some responsibility for [that individual's] safety and general well-being. *Jordan v. District of Columbia*, 161 F. Supp. 3d 45, 53 (D.D.C. 2016) (quoting *DeShaney v. Winnebago Cnty. Dep't of Social Servs.*, 489 U.S. 189,

197, (1989), and citing *Harvey v. District of Columbia*, 798 F.3d 1042, 1050-51 (D.C. Cir. 2015) (discussing *DeShaney* in the involuntary commitment context) (alterations in the original)); *Moses v. District of Columbia*, 741 F.Supp.2d 123 (D.D.C. 2010). Due process standards for civil detainees, like those for pretrial detainees, are higher than those under the Eighth Amendment for individuals convicted of crimes: "[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982).

If the Court finds here that the conditions are objectively unreasonable and/or fail to ensure Plaintiffs' safety and well-being, then Plaintiffs and class members—all of whom are civil or pretrial detainees and none of whom has been convicted of a crime—have made out a Fifth Amendment claim regardless of Defendants' subjective intent. *See id.; accord Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017) ("[T]he Due Process Clause can be violated when an official does not have subjective awareness that the official's acts (or omissions) have subjected the pretrial detainee to a substantial risk of harm."). The following analysis relies on due process cases under both the Fifth Amendment (which applies here, because the governmental actor is the District of Columbia, see *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954)) and the Fourteenth Amendment, because the due process protections under both clauses are the same, *Doe v. District of Columbia*, 206 F. Supp. 3d 583, 603 n.11 (D.D.C. 2016); Plaintiffs also rely on Eighth Amendment cases because a non-convicted detainee's rights "are at least as great as the Eighth Amendment protections available to a convicted prisoner," *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983); *see also Cty. of Sacramento v. Lewis*, 523 U.S. 833, 850 (1998) (explaining that treatment that would violate a convicted person's Eighth Amendment right a fortiori violates a pretrial detainee's due process right).

Among the most basic rights of civil and pretrial detainees are the right to adequate medical care, *Youngberg*, 457 U.S. at 324 (1982), and reasonable safety in confinement, *see Helling v. McKinney*, 509 U.S. 25, 33 (1993) (holding that even convicted individuals may not be subjected to "a condition of confinement that is . . . very likely to cause serious illness and needless suffering."). Even for convicted individuals, the right to medical care includes the right to mental health care. *See Brown v. Plata*, 563 U.S. 493, 506 (2011). The record evidence — in the form of sworn affidavits from residents in Defendants' custody and from attorneys and investigators from PDS who have witnessed first-hand the conditions of Defendants' facilities, and expert declarations from infectious disease and mental health specialists — amply demonstrates the breadth and scope of Defendants' unconstitutional actions and inactions in unreasonably failing to provide adequate medical care and to protect the health and safety of Plaintiffs.

During the COVID-19 outbreak, St. Elizabeths has responded by housing symptomatic and COVID-19 positive individuals together with asymptomatic individuals, potentially exposing individuals who do not have COVID-19; the Hospital has also failed to isolate and quarantine individuals with the virus or suspected of having the virus. This is almost exactly the situation the Supreme Court described in *Helling*, where inmates in "isolation were crowded into cells" with individuals with "infectious maladies." *Id.* The Hospital has compounded this failure during the COVID-19 crisis by failing to provide basic sanitation appropriate to the situation—in this case, ample soap and hand sanitizer, increased cleaning and disinfection of areas. *See Williams v. Griffin*, 952 F.2d 820, 825 (4th Cir. 1991); *Walker v. Schult*, 717 F.3d 119, 126-27 (2d Cir. 2013); *Gates v. Cook*, 376 F.3d 323, 338 (5th Cir. 2004); *McBride v. Deer*, 240 F.3d 1287, 1291-92 (10th Cir. 2001). Significant deficiencies in hygienic conditions violate the constitutional rights of prisoners. *See Caldwell v. Caesar*, 150 F. Supp. 2d 50, 64 (D.D.C. 2001). Notably, Plaintiffs do

not need to show that they are currently infected or suffering "serious health problems" to show that they face a "substantial risk" of serious harm that is unconstitutional. *Helling*, 509 U.S. at 34. On the contrary, the Supreme Court rejected the notion that "prison authorities ... may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Id.* at 33. Even more specifically, the Court held that prison authorities could not escape responsibility for preventing "the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms." *Id.*

Essential mental health care has been severely curtailed during the COVID-19 outbreak. Large numbers of staff have called in sick, the Treatment Mall has been closed, and patients are not receiving necessary care. It bears emphasis that the CDC Guidance specifically instructs institutions to "plan for staff absences" including making a "plan for alternative coverage by cross-training staff" and "develop[ing] a plan to secure additional staff."[40] The Hospital appears to have failed to implement any of these measures.

Ample record evidence, expert reports, and persuasive decisions from other circuits demonstrate that patients at the Hospital face a substantial risk of contracting COVID-19. The record evidence shows that Plaintiffs and proposed class members face a "substantial risk" of contracting COVID-19. Most significantly, according to Defendants, there are already 79 confirmed cases of COVID-19 in their facilities—51 staff and 33 patients. And 156 persons—74 patients and 82 staff are in isolation or quarantine.

[40] CTRS. DISEASE CONTROL & PREVENTION, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

In his expert declaration, Dr. Golob explains that infections like COVID-19 can spread more rapidly in congregate environments, "particularly where residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff." Golob Decl. ¶ 13.

This risk is intolerable. *Cf. Helling*, 509 U.S. at 36 (asking "whether society considers the risk that the prisoner complains of to be so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk."). The available data from the CDC show that of Americans generally who tested positive for COVID-19, nearly a third require hospitalization, many of those require admission to the ICU, and between 1.8 and 3.4 percent of people die. From a clinical and public health perspective, COVID-19 poses a risk of serious harm to anyone who contracts it. Dr. Golob explains that this severe risk extends not only to the elderly, but to "younger and healthier people" for whom "infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation." Golob Decl. ¶ 5.

The declarations of emergency from nearly every level of government is strong evidence COVID-19 is a risk that society considers to be grave. In declaring a national emergency on March 13, 2020, President Trump proclaimed that "[t]he spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems."[41]. Mayor Bowser's Declaration of Public Health Emergency includes the finding that COVID- 19 "poses a significant risk of substantial future harm to a large number of people in the District of Columbia."[42]

[41] Exec. Order No. 9994, 85 Fed. Reg. 15337 (Mar. 13, 2020), *available at* https://www.govinfo.gov/content/pkg/FR-2020-03-18/pdf/2020-05794.pdf.
[42] Mayor's Order 2020-046, § I(C) (Mar. 11, 2020), *available at* https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/release_content/attachments/MO.DeclarationofPublicHealthEmergency03.11.20.pdf.

For these and other reasons, many courts have recognized that COVID-19 poses a risk of serious harm. The Court in *Basank v. Decker*, No. 20-cv-2518 (AT), 2020 WL 1481503 (S.D.N.Y. Mar. 26, 2020), pointed to "[a] number of courts in this district and elsewhere [that] have recognized the threat that COVID-19 poses to individuals held in jails and other detention facilities." *Id.* at *3 (citing *United States v. Stephens*, No. 15-cr-95 (AJN), 2020 WL 1295155, at *2 (S.D.N.Y. Mar. 19, 2020); *United States v. Garlock*, No. 18-cr-418 (VC), 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020)). The New Jersey Supreme Court, in approving an order resulting in the release of approximately 1,000 people from New Jersey jails, described "the profound risk posed to people in correctional facilities arising from the spread of COVID-19." *In the Matter of the Request to Commute or Suspend County Jail Sentences*, Case No. 84230 (N.J. March 22, 2020). Even this Court's own operations have been dramatically changed by the "pandemic," in Chief Judge Howell's words, "reflecting the seriousness of the need to combat the community spread of the virus." *In re: Court Operations in Exigent Circumstances Created by the COVID-19 Pandemic*, Standing Order No. 20-9 (BAH), at 1–2.

To recognize the gravity of the risk, the court need look no further than statements of the District's own officials, including Defendant Bazron. Mayor Bowser herself announced on March 11, 2020, that COVID-19 "poses a significant risk of substantial future harm to a large number of people in the District of Columbia." Mayor's Order 2020-046, § I(C) (March 11, 2020). And in response to a letter from Plaintiffs' counsel, Defendant Barzon recognized "the significant perils posed by the highly communicable coronavirus." Defendant Barzon advised that on March 12, the Hospital activated its Emergency Preparedness Plan.

Plaintiffs and proposed class members are likely to prevail in showing that Defendants have disregarded and continue to disregard the excessive risk to their health or safety. Ms. Jones notes that the conditions at the Hospital are "a clear risk to health and safety." Jones ¶ 16.

The very failures of Defendants in this case have been found to constitute deliberate indifference in like cases. For instance, in *Feliciano v. Gonzales*, 13 F. Supp. 2d 151 (D.P.R. 1998), the Court found that the defendant's "inability . . . to properly isolate cases of active tuberculosis," the "insufficient medical dormitory beds," the failure to "fully screen incoming inmates," and the failure to "provide for a sick call system that ensures access to care and that is capable of effectively handling emergencies" constituted deliberate indifference. *Id.* at 208–09. In other cases, the defendant's inability to "adequately quarantine or remove inmates and support staff known to have active tuberculosis" was found to constitute deliberate indifference. *See Shimon v. Dep't of Corr. Servs. for N.Y.*, No. 93-cv-3144 (DC), 1996 WL 15688, at *1 (S.D.N.Y. Jan. 17, 1996). And in *Joy v. Healthcare CMS*, 534 F. Supp. 2d 482 (D. Del. 2008), the Court found that the plaintiffs stated a claim under the Eighth Amendment where the warden "was aware that inmates were not thoroughly screened for disease before going into general population and that Correctional Medical Services does not have a policy in place to examine inmates before placing them into general population." *Id.* at 485. As discussed above, the record is replete with Defendants' deficient performance in all of these categories, including their failed quarantine policy, rampant medical delays, and ineffective screening procedures.

Defendants' failure to protect Plaintiffs and the objective unreasonableness of their conduct can also be shown by reference to their failure to follow accepted medical standards—a showing that suffices to meet even the Eighth Amendment standard that is more demanding than due process. The Court in *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929 (N.D. Cal. 2015), explained that

"known noncompliance with generally accepted guidelines for inmate health strongly indicates deliberate indifference to a substantial risk of serious harm." *Id.* at 943. Here, Dr. Stern's declaration makes clear that Defendants are out of compliance in critical categories, including screening and testing policies, social distancing requirements, medical isolation, and quarantine protocols. Stern Decl. ¶ 16.

Defendants are also unnecessarily and discriminatorily institutionalizing patients who could be served in a community-based placement because to date they have failed to evaluate and develop release plans. While, under Title II of the ADA, a public entity may rely on the assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program, those assessments must be reasonable. *Olmstead v. L.V. by Zimring, 527 U.S. 581, 602.*Defendant's actions, and inactions, in addressing the COVID-19 pandemic have created an unreasonable risk of harm to Plaintiffs' mental and physical health which undermines any previously existing justification for their institutionalization. Defendants' failure to evaluate all patients for community placement does not allow the conclusion that plaintiffs isolation is currently justified. *See Long v. Benson*, No. 08-0026, 2008 U.S. Dist. LEXIS 109917, 2008 WL 4571904, at *2 (N.D. Fla. 2008) (refusing to limit class to individuals whom state professionals deemed could be treated in the community, because a State "cannot deny the [integration] right simply by refusing to acknowledge that the individual could receive appropriate care in the community. Otherwise the right would, or at least could, become wholly illusory."). Plaintiffs are in danger of contracting a highly communicable, potentially fatal virus. The very treatment they were institutionalized to receive, intensive inpatient psychiatric care, is not taking place. Given these circumstances, continued segregation and institutionalization of plaintiffs is not reasonable.

In short, even as to convicted individuals (which Plaintiffs are *not*), a facility "that deprives [persons] of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Brown v. Plata*, 563 U.S. 493, 510–11 (2011). Given the grave risk of infection during the COVID-19 pandemic, the conditions to which Defendants are subjecting Plaintiffs in Saint Elizabeths Hospital fall below basic standards of decency, are objectively unreasonable, fail to ensure plaintiffs' reasonable safety, and therefore violate due process. While Defendants may have had reasonable assessments justifying the institutionalization of plaintiffs in a functioning, safe psychiatric facility, the equities have shifted in light of the COVID-19 pandemic such that the risks to plaintiffs physical and mental health outweigh and limited benefit of inadequate mental health treatment they will receive for the duration of the public health emergency.

2. Plaintiffs Will Suffer Irreparable Harm Unless Defendants Are Enjoined from Following a Policy that Will Allow them to be Housed in Unconstitutional Conditions in the Future

As discussed above, Plaintiffs' constitutional and statutory rights are being deprived, and nothing more is needed to prove irreparable harm, because the deprivation of constitutional rights, "for even minimal periods of time, unquestionably constitutes irreparable injury." *Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009); *Mitchell v. Cuomo*, 748 F.2d 804, 806 (2d Cir. 1984) ("When an alleged deprivation of a constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary.") (citing 11 C. Wright & A. Miller, Federal Practice and Procedure § 2948.1 (1973))); *see generally Brown v. Plata*, 563 U.S. 493, 511 (2011) ("Courts . . . must not shrink from their obligation to enforce the constitutional rights of . . . prisoners." (internal quotation marks and citation omitted)). In *Olmstead v. Zimring*, the Court was concerned with two distinct harms people with disabilities suffer when subjected to

discriminatory unjustified isolation. *Olmstead v. L. C. by Zimring*, 527 U.S. 581, 600. First, the Court was concerned with the stigma society places on individuals with disabilities when they are isolated and, secondly, the Court was concerned that individuals with disabilities so isolated have severely diminished everyday life activities, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. *Id.* And even if Plaintiffs did not suffer constitutional injury, these facts demonstrate irreparable harm, as discussed below.

Plaintiffs are individuals with seriously mental illnesses, many involuntarily housed in a psychiatric hospital. During the pandemic, they have been unnecessarily exposed to the coronavirus without adequate means to protect themselves, have been grouped with individuals who likely have COVID-19, and have not received adequate care when they exhibit symptoms of the disease. Every day, they are deprived of the soap, hand sanitizer, and masks to allow them to adequately mitigate their risk of infection. Every day, they are being deprived of the mental health care that is the purpose of their commitment to the hospital.

Elizabeth Jones has over 35 years of experience managing the provision of services to people with intellectual and behavioral health disabilities, including managing public sector psychiatric hospitals in the District of Columbia, Massachusetts, and Maine. Jones Decl. ¶ 1. She was the Hospital Director at St. Elizabeths Hospital from February 1998 through April 2000 at which time she became Chief Operating Officer for the District of Columbia's Commission on Mental Health Services while it was under federal court receivership. *Id.* at ¶ 5. According to Jones, delays in the treatment of a physical illness of a patient who has been institutionalized can result in feelings of isolation, hopelessness, and despair, as well as increased stress and anxiety. *Id.* at ¶ 11. St. Elizabeths' failure to provide safety, security, predictability, and continuity of care

is counter to effective treatment and has resulted in fear and actual harm, including regression, loss of self-esteem, and exacerbation of distress and heightened instability, leading to longer lengths of hospitalization and the likelihood of more restrictive measures such as loss of privileges or the use of seclusion or restraints. *Id.* at ¶ 12. Jones has concluded based on her review of the statements of the Plaintiffs that the conditions at St. Elizabeth's Hospital presented a clear risk to health of safety and drastic deterrents to treatment, recovery, and timely discharge of the its patients. *Id.* at ¶ 16.

Every day during the current crisis, Plaintiffs are being deprived of the essentials of the care that the District is required to provide. *See Youngberg*, 457 U.S. at 324. As described by Jones, irreparable harm is occurring with each passing day as the conditions at St. Elizabeth's "inevitably will result in long lasting, if not permanent, damages to the patients and their efforts at recovery" (Jones Decl. ¶ 16), demonstrating the need for the relief Plaintiffs seek here.

In addition to the present danger, there is a serious danger of recurrent violation because this is the third time in three years that patients at St. Elizabeths have been subjected to dangerous conditions of various kinds when, in the face of a crisis at the Hospital, Defendants failed to respond with necessary measures to protect patients. The Defendants' Emergency Protocols have now thrice failed to provide safe or humane conditions of confinement, or adequate mental health or other care during a crisis.

3. Enjoining Defendants from Failing to House and Treat Involuntarily Committed Persons in Conditions that Meet the Most Basic Standard of Decency Will Not Substantially Injure Defendants or Other Interested Parties

As discussed, *supra*, Plaintiffs and others similarly situated, will suffer irreparable harm in the absence of relief from this Court. In contrast, the injunction would impose no measurable harm on Defendants. When a government entity involuntarily commits persons to its custody, it has an

obligation to provide essentials. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982). Defendants have no legal right to confine Plaintiffs and others where they are exposed to a dangerous and life-threatening risk.

As outlined in the relief section, there are measures Defendants can take to address the risks of COVID-19 as well as patient and public safety that would allow Defendants to transfer Plaintiffs and other similarly situated individuals to other appropriate facilities or discharge them (where appropriate) to community-based care. Indeed, it is Defendants' affirmative obligation to do so when circumstances exist such that the isolation of individuals with disabilities is no longer justified. The ADA seeks to prevent not only intentional discrimination against people with disabilities, but also—primarily—discrimination that results from "thoughtlessness and indifference," that is, from "benign neglect." *Alexander v. Choate*, 469 U.S. 287, 301 (1985); see H.R. Rep. No. 101-485(II), at 29 (1990). Thus, the law requires "affirmative accommodations to ensure that facially neutral rules do not in practice discriminate against individuals with disabilities." *Henrietta D. v. Bloomberg*, 331 F.3d. 261, 275 (2d Cir, 2003); *see also Tennessee v. Lane*, 541 U.S. 509, 511 (2004) ("Recognizing that failure to accommodate persons with disabilities will often have the same practical effect as outright exclusion, Congress required the States to take reasonable measures to remove . . . barriers to accessibility."); 42 U.S.C. § 12112(b)(5)(A) (defining discrimination to include failing to "mak[e] reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability"). Defendants' continued isolation of Plaintiffs due to their refusal to modify their evaluation and release policies in light of the COVID-19 pandemic is unreasonable and the risks Plaintiffs and Plaintiffs class are being subjected to in this case are even more egregious than the facts in *Alexander v. Choate* as Defendant's indifference towards Plaintiffs is not benign, but subjects them

to an unreasonable risk of contracting a highly communicable, potentially fatal virus all while depriving them of necessary mental health services. Defendants provide a wide array of services in the community to meet the needs of Plaintiffs including diagnostic/assessment services, counseling, medication, intensive day treatment and crisis/emergency services.[43] Individualized behavioral health services are supported by rehabilitation programs, peer supports, supportive employment opportunities, housing assistance and a range of community housing alternatives to facility-based care.[44] These services are being provided by Defendants during the COVID-19 crisis and could be provided to Plaintiffs and Plaintiff class in the community.

As described in the Jones Declaration, this process would involve conducting an individualized assessment of each patient by St. Elizabeths staff. Jones Decl. ¶ 17(b). This assessment could be made by the Medical Director, and would require consideration of whether other options exist in lieu of continued placement at St. Elizabeths. Jones Decl. ¶ 17(d). Because the assessments could be made with current employees of Defendants and the costs of placing patients in community settings or to private hospitals are roughly comparable (if not less expensive) than housing the individuals at St. Elizabeths, there is no reason to believe that ordering the requested relief will substantially injure Defendants.

Similarly, there is no reason why Defendants should not stop the admissions of new patients. Individuals who would ordinarily be sent to Saint Elizabeths can be sent to a community setting with support, or if supervision is essential, to a private psychiatric hospital in the District, and there is no reason to believe that ordering such relief will substantially injure Defendants.

[43] Dist. Of Columbia, Dep't of Behavioral Health, *Adult Services*, available at https://dbh.dc.gov/service/adult-services
[44] *Id*.

4. A TRO Will Serve the Public Interest.

The public interest is served when constitutional and statutory rights are protected. "It is always in the public interest to prevent the violation of a party's constitutional rights." *Simms v. District of Columbia*, 872 F. Supp. 2d 90, 105 (D.D.C. 2012) (quoting *Abdah v. Bush*, No. 04-cv-1254, 2005 WL 711814 at *6 (D.D.C. Mar. 29, 2005)); *accord Lamprecht v. F.C.C.*, 958 F.2d 382, 390 (D.C. Cir. 1992) ("a [government] policy that is unconstitutional would inherently conflict with the public interest"). In the instant case, the public interest would be vindicated by honoring individual civil rights and restoring basic standards of decency to the treatment of Plaintiffs and other patients at the Hospital during future crises. As long as departing residents are held in appropriate isolation, the risk to public health is much greater keeping them at Saint Elizabeths than transferring them elsewhere or letting them out—inside the facility, they will continue to spread COVID-19 within the congregate setting and infect more staff, who will further infect the community. Outside, they can self-isolate after quarantine just as the Mayor has ordered everyone else to do.

REQUESTED REMEDY

Defendant's policies and practices have led to untenable conditions that have placed patients at Saint Elizabeths at an "imminent and heighted risk from COVID-19." Stern Decl. ¶ 12. Further, Defendants have deprived patients of necessary care and created a chaotic environment that, if allowed to continue, will be "drastic deterrents to treatment, recovery and timely discharge." Jones Decl. ¶ 16. The Court should order emergency relief to accomplish two things. First, it should order the Department of Behavioral Health to follow public health guidelines for preventing and controlling the spread of COVID-19 at Saint Elizabeths Hospital, including, after conducting individualized assessments, significantly reducing the patient population at the Hospital. Second,

it should enjoin Defendants from further damaging Plaintiffs' mental health by continuing lack of essential treatment.

1. Significant downsizing of Saint Elizabeths Hospital is the most effective way to prevent and control the spread of COVID-19 among the patients. Stern Decl. ¶¶ 13-15; Jones Decl. ¶¶ 17(a) & 17(j)(ii). To this end, the Court should order Defendants to:

a. Cease all admissions to the Hospital until the density at St. Elizabeths is sufficiently reduced to allow for social distancing and patients at the hospital are no longer at a heightened risk due to COVID-19;

b. Conduct an individualized assessment of each patient, within 48 hours, to assess the current effect of these conditions on the patient and to determine whether other options exist in lieu of continued placement at St. Elizabeths. This assessment should be conducted with input from the patient's treatment team, the patient's attorney, and/or the protection and advocacy agency for the District.

c. Evaluate all patients for community placement, conduct a risk assessment, identify potential community-based supports that build on existing systems of care, and then, whenever possible, recommend release.

d. Implement release recommendations from the assessment team consistent with public health guidelines for quarantining and isolating patients who may have been exposed to COVID-19.

e. Develop a staffing contingency plan that includes employing sufficient qualified temporary staff to ensure adequate infection control and that patients receive necessary treatment and care in light of staffing shortages.

2. To the extent continued placement at St. Elizabeths is the only reasonable option for some individuals, the Court should order Defendants to:

a. Provide appropriate COVID-19 intervention and care at the Hospital, including (i) evaluating patients and where appropriate administering rapid COVID-19 tests; (ii) ensuring clinically effective isolation and quarantine for patients with confirmed and suspected COVID-19 cases; and (iii) determining equipment needs and immediately providing masks for any individuals displaying or reporting COVID-19 symptoms or exposure until they can be evaluated by a qualified medical professional or placed in quarantine;

b. Ensure that each patient has timely and complete access to essential hygiene, including soap, hand sanitizer, and running water, and materials needed to disinfect surfaces that may be contaminated;

c. Develop capacity for patients, who are not infected and for whom release is not possible, to be housed in an auxiliary facility until the density at St. Elizabeths is sufficiently reduced to allow for social distancing, and implement social distancing in accordance with public health guidelines.

d. Ensure robust education about COVID-19 for patients, including education about how to identify symptoms, how to take preventative measures, how to contact patient advocates, and about any changes in policies and practices at the Hospital. There should be sufficient opportunity to ask and receive answers to questions.

3. The conditions at Saint Elizabeths are also causing irreparable harm to the Plaintiffs. All patients at Saint Elizabeths are, by definition, in need of psychiatric care. Yet during this crisis, Defendants have ceased providing key components of that care and are not systematically

providing alternatives that can be implemented consistent with COVID-19 public health guidelines, such as virtual or telemedicine alternatives. To remedy this, the Court should order Defendants to conduct individual assessments of each patient, with input from the patient's treatment team, the patient's attorney, and/or other supportive decision makers as determined by the patient, to assess the effects of the stress and trauma of the current COVID-19 pandemic and the repercussions that Defendants' deprivation of appropriate mental health services has had on the patient'' mental health status. If the assessment determines that changes to a patient's treatment plans are needed, such changes should be implemented immediately.

4. Finally, the Court should order that the Defendants provide the Court and Plaintiffs with daily reports to ensure that the measures laid out in the Court's order are being followed. To that end, the daily report should include (i) the daily census of patients, (ii) the number of admissions, (iii) the number of individualized assessments completed, (iv) the number of patients the assessment team has recommended released and the number of patients recommended for release or change in treatment, as well as any instance where the recommendation for release or treatment has not been implemented, (v) for any patient remaining in the facility, their COVID-19 status and their quarantine or isolation status, (vi) the daily staff census, and (vii) all complaints reported to the Hospital's patient advocate.

Dated: April 16, 2020

Respectfully submitted,

/s/ John A. Freedman

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I, Elizabeth Jones, declare and state the following:

Relevant Experience

1. I have over 35 years of experience managing the provision of services to people with intellectual and behavioral health disabilities, including managing public sector psychiatric hospitals in Massachusetts, Maine, and the District Columbia.

2. I currently serve as the court-appointed Independent Reviewer in *United States v. Georgia*, Civ. Action No. 1:10-CV-249-CAP, overseeing implementation of a federal consent decree requiring the development of integrated community-based services and supports as alternatives to institutionalization for individuals with developmental disabilities and/or mental illness in the State of Georgia.

3. From 2004 until 2017, I served as the Court Monitor in *Evans v. Bowser*, Civ. Action No. 76-293, a federal class action lawsuit concerning the care and treatment of people with intellectual and developmental disabilities in the District of Columbia. As Court Monitor, I oversaw and reported on implementation of court orders related to the development of community-based, individualized services/supports for former residents of the District- operated Forest Haven institution (now closed) for children and adults with intellectual and/or developmental disabilities.

4. From 2001 until 2004, I was the Senior Planner for the District of Columbia's newly formed Department of Mental Health, where I was responsible for planning systemic initiatives that improve the quality of care/treatment for individuals with serious mental illness.

5. I was the Hospital Director for St. Elizabeths Hospital from February 1998 through April 2000. I then became the Chief Operating Officer for the District of Columbia's Commission on Mental Health Services while it was under federal court receivership.

6. I have reviewed the April 16, 2020 Amended Complaint in *Costa v. Bazron*, No 1:19-cv-3185 (RMD)(DDC) and the declarations of Hadley Truettner, Ashley Guzman, Wanda Rose, Penelope Donkar and Danielle Mason.

Patients at St. Elizabeths Hospital

7. Individuals who have been admitted to St. Elizabeths Hospital have serious and persistent mental illness and have been determined by the District to need intensive inpatient care to support their recovery.

8. Admission to a psychiatric institution is a serious decision that seeks to prevent or ameliorate harm; enable an individual to return to a productive life as a member of his or her community; and provide a dignified, respectful and supportive environment characterized by stability, security, and generally accepted standards of individualized treatment, continuity of care, professionalism, health, and safety. Institutionalization should be a last resort when community supports are not sufficient and as short as is necessary to provide treatment of care that would permit the individual to live in a more integrated setting.

9. To achieve these goals, the hospital setting must be safe, calm, predictable in its routine, and responsive to each individual's needs for treatment.

10. An environment that is chaotic, unpredictable, and unsafe, and in which patients are not receiving individualized, continuous, intensive treatment risks traumatizing people further and exacerbating the psychiatric needs that were the basis for their admission.

11. Since institutionalization in a psychiatric facility restricts self-determination, freedom of movement, curtailment of access to social networks and integration into community-based settings and activities, delays in the treatment of a psychiatric illness in this setting can result in feelings of isolation, feelings of hopelessness, despair and increased stress/anxiety.

12. The failure to provide safety, security, predictability, and continuity of care is counter to effective treatment and results in fear of harm and actual harm, including regression, loss of self-esteem, and exacerbation of distress and heightened instability, leading to longer lengths of hospitalization and the likelihood of more restrictive measures, such as loss of privileges or the use of seclusion and/or restraints.

Effects of Current Conditions at St. Elizabeths Hospital

13. As reported to me in the declarations cited above, patients at St. Elizabeths are not receiving their regular psychiatric care. Patients are confined to their units and their rooms and are unable to attend regularly scheduled therapy. Patients have not been provided with any consistent alternative virtual or telephonic therapy.

14. It is my understanding that treatment planning meetings, observation of the implementation of treatment plans, requisite documentation, and other expected activities and oversight are not able to take place because of the chaotic situation created by COVID-19.

15. It is my understanding that patients at Saint Elizabeths Hospital are not able to maintain six feet of distance between themselves and other people ("social distancing") and are sharing common space with other patients and staff on their Units. It is my understanding, based on the documents I have reviewed, that patients are not being tested for COVID-19 rapidly; asymptomatic patients are not being quarantined or isolated from patients who have tested positive for COVID-19 or who have been exposed to COVID-19; and that there are large staff absences from Saint Elizabeths.

16. The conditions at St. Elizabeths Hospital, as described to me, are a clear risk to health and safety. They are drastic deterrents to treatment, recovery and timely discharge. They risk traumatizing patients and exacerbating symptoms of mental illness and inevitably will result

in long lasting, if not permanent, damage to the individuals and their efforts at recovery. Without a doubt, these circumstances violate professional standards of care and treatment.

Remedy

17. The current conditions at St. Elizabeths Hospital, as described to me, are shockingly unacceptable and immediate action needs to be taken to prevent further harm. Based on my experience managing the provision of treatment to individuals with mental illness in the District, including at St. Elizabeths Hospital, and elsewhere, I recommend the following steps be taken:

a. Cease all admissions to the Hospital until the density at St. Elizabeths is sufficiently reduced to allow for social distancing.

b. Ensure that each patient has a treatment plan to mitigate the trauma of the current conditions.

c. The Medical Director at Saint Elizabeths Hospital should conduct individual assessments of patients with input from the patients' treatment team, his/her attorney, and/or other supportive decision makers as determined by patient choice to assess the effects of the stress and trauma of the impact of the current COVID-19 pandemic, and the repercussions Defendants' deprivation of appropriate mental health services has had on patients' mental health status and determine if changes to individual patients' treatment plans are needed and implement any changes and recommendations from the individualized assessments immediately.

d. The Medical Director at St. Elizabeths Hospital should conduct an individualized assessment of each patient to assess the current effect of these conditions on the patient and determine whether other options exist in lieu of continued placement at St. Elizabeths. This assessment should be conducted with input from the patient's treatment team,

his/her attorney, and/or the protection and advocacy agency for the District.

e. The assessment team, as described above, should evaluate all patients for community placement, conduct a risk assessment, identify potential community-based supports that build on existing systems of care, and then, whenever possible, recommend release.

f. In making this determination, the Medical Director must consider a full range of alternative treatment options, including those currently or potentially available in the community.

g. Some individuals may be able to be discharged to a community setting with support, for example, from an Assertive Community Treatment (ACT) Team or other community-based supports.

h. Action should be taken in each case in a timely manner. All assessments must be completed within 48 hours and the recommendations from the assessments must be implemented immediately.

i. Under no circumstances should an individual be transferred to a nursing home or jail.

j. If continued placement at St. Elizabeths is the only reasonable option, then the following should occur:

i. Provide appropriate COVID-19 intervention and care at the Hospital with teams of medical professionals and infection experts who can:

a. Develop, update, and implement best practices for reducing the infection rates at Saint Elizabeths Hospital, including providing appropriate and accessible guidance to staff and patients;

b. Administer rapid COVID-19 tests for anyone displaying known symptoms of COVID-19 or who has been exposed to someone with known symptoms or who has tested positive for COVID-19;

c. Ensure segregation of confirmed and suspected COVID-19 cases;

d. Determine equipment needs and immediately provide masks for any individual displaying or reporting COVID-19 symptoms or exposure until they can be evaluated by a qualified medical professional or placed in quarantine;

e. Ensure that each patient has timely and complete access to essential hygiene;

f. Provide on-site care and medical assessment, including medical care and therapy that is appropriate for each individual's needs.

ii. Develop capacity for patients, who are not infected and for whom release is not possible, to be housed in an auxiliary facility until the density at St. Elizabeths is sufficiently reduced to allow for social distancing, and implement social distancing in accordance with public health guidelines.

iii. Frequently communicate with patients to provide information about COVID-19, reducing the risk of transmission, and any changes in policies or practices.

iv. Ensure robust education to patients, including sufficient opportunity to ask and receive answers to questions about COVID-19, how to identify symptoms, and how to take preventative measures.

v. Ensure expedited access to both independent and internal patient advocates in order to address any patient concerns about their medical care or the conditions in the Hospital.

vi. Assigned dedicated staff to each Unit and do not move staff between Units except to comply with public health recommendations regarding the segregation of people with COVID-19 symptoms, exposure, or positive tests so that patients develop a relationship with the staff person who is caring for them.

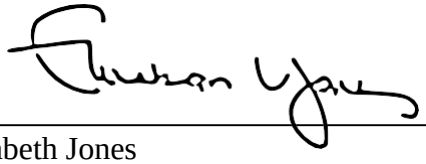
vii. Ensure patients are able to go outside daily and recreate while maintaining appropriate social distance.

18. Develop a staffing contingency plan that includes employing sufficient qualified temporary staff to ensure adequate infection control and that patients receive necessary treatment and care in light of staffing shortages.

19. Provide daily reporting to the Plaintiffs' attorneys about the number of patients, their COVID-19 status, their quarantine status, the number of staff who reported to work, the number of restraint and seclusion events (including medical restraint), and all complaints reported to the Hospital's patient advocate.

20. The Court should continue to provide oversight until these damaging and utterly substandard circumstances have ended. A timetable should be agreed upon and penalties should be assessed if the timelines are not met.

I declare, under penalty of perjury, that the forgoing is true and correct. Executed on April 17, 2020.



Elizabeth Jones

RESUME

ELIZABETH JONES

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EDUCATION

Bachelor of Arts, English, University of California at Santa Barbara, 1972.

Graduate work (20 credit hours) in Educational Psychology, Georgia State University, Atlanta, GA, 1976-77.

Master of Science, Labor Studies, University of Massachusetts, Amherst, Labor Relations and Research Center, 1982. Thesis focused on the Rhode Island Labor/Management agreement regarding the transfer of public employees from institutional to community-based programs.

Program for Senior Executives in the Commonwealth of Massachusetts, Kennedy School of Government, Cambridge, MA, 1983.

Web-based Certificate Course in Supported Employment, Virginia Commonwealth University, Rehabilitation Research and Training Center on Workplace Supports, Richmond, VA, 2002.

WORK EXPERIENCE

October 28, 2010 to present: **Independent Reviewer**
United States v. State of Georgia

With agreement of the Parties, appointed by the United States District Court to review the State of Georgia's implementation of a Settlement Agreement requiring the development of integrated community-based services and supports as alternatives to institutionalization for individuals with developmental disabilities and/or mental illness.

February 10, 2004 to January 10, 2017: **Court Monitor**
Washington, DC

Appointed as Court Monitor in Federal Court class action litigation, Evans v. Bowser, brought to compel the development of community-based, individualized services/supports for former residents of the District-operated Forest Haven institution

(now closed) for children and adults with intellectual and/or developmental disabilities. Responsibilities included oversight of all monitoring activities, management of the Court Monitoring Office, reporting to the Federal Court, and working with the Parties to identify issues/concerns affecting compliance with longstanding court orders and agreements.

November 5, 2003 to December 31, 2004: **Receiver**
Riverview Psychiatric Center/Augusta Mental Health Institute
Augusta, ME

Appointed by the Maine Superior Court in the Bates v. Harvey case, class action litigation brought in 1989 to ensure the provision of mental health treatment to current and former clients of the Augusta Mental Health Institute. Responsibilities included oversight of all Hospital management and operations, preparation and implementation of a work plan that will lead to compliance with the Consent Decree, and monthly reporting to the Court. The Receivership was vacated by the Law Court of Maine in December 2004.

August 1, 2001 to February 10, 2004: **Senior Planner**
District of Columbia
Department of Mental Health
Washington, DC

Within the newly formed Department of Mental Health, responsible for planning systemic initiatives that improve the quality of care/treatment for individuals with serious mental illness. Major responsibility for the Department's evidence-based supported employment initiative, including the Ticket to Work; development of core curriculum for employment specialists; implementation of the Johnson & Johnson-Dartmouth Community Mental Health Program grant award; data analysis of existing employment services; restructuring employment models no longer considered consistent with best practices; and interagency collaboration to expand employment options for adults and youth with serious mental illness/emotional disturbance. Additionally, exercised major responsibility for interagency efforts to improve services/supports for those clients with a dual diagnosis of mental illness/intellectual disability.

June 1, 2000 to August 1, 2001: **Chief Operating Officer**
District of Columbia
Commission on Mental Health Services
Washington, DC

April 1, 2000 to June 1, 2000: **Acting Chief Operating Officer**

Under the direction of the Transitional Receiver, responsible for the day to day operations of the Commission including supervision of all administrative and programmatic functions; working with other government agencies and providers of services/supports to

the Commission and its clients; collaborating with consumer groups, advocates, family groups and other interested parties to strengthen the mental health system's responsiveness and effectiveness in meeting its mandates; participating in the design and implementation of systemic reform initiatives; overseeing the investigation and resolution of concerns impeding the delivery of services/supports of the highest possible quality.

February 1998 to April 2000: **Hospital Director**
St. Elizabeths Hospital
Washington, DC

Overall management responsibility for the Acute Care and Continuing Care programs of a public psychiatric hospital then under Federal Court receivership pursuant to orders in the Dixon case, a longstanding class action lawsuit mandating the development of a comprehensive community based mental health system.

Responsibilities included direction and oversight of the provision of active treatment to approximately 375 clients; identification of appropriate community services for individuals no longer requiring stabilization in an inpatient setting; management of personnel and budget; work with advocates, families, legal representatives, community providers, community advocacy groups and public officials. As a member of the senior executive staff, responsible for working with the Receiver and colleagues to design, implement and evaluate strategies for systemic reform. Also responsible for the overall management of the CarePoint Project, an initiative designed to substantially reform and improve the provision of individualized services and supports.

June 1990 to February 1998: **Executive Director**
Disability Rights Maryland
Baltimore, MD.

Disability Rights Maryland, formerly known as the Maryland Disability Law Center, is a public interest law firm funded mainly through federal and state grants and contracts. Pursuant to federal law, it has been designated since 1977 as the Protection and Advocacy System for the State of Maryland. Reporting to an independent Board of Directors, responsibilities as Executive Director included supervision of thirty-six staff, including thirteen attorneys and nine paralegals, and management of a two million dollar budget. Responsibilities also included planning, program implementation, liaison with advocacy groups and state agencies, public relations and playing a key role in the disability and public interest community.

July 1986 to June 1990: **Coordinator**
Dixon Implementation Monitoring Committee
Washington, D.C.

Coordinator for the Dixon Committee, a monitoring group established in 1980 by Federal District Judge Aubrey Robinson in the Dixon lawsuit. The Committee was mandated to

receive and analyze defendant's reports and factual investigations; screen and investigate complaints; oversee and report on the progress of the implementation of the Court's decrees. Responsibilities as Coordinator included advising plaintiffs' attorneys at the Mental Health Law Project (now the Bazelon Center for Mental Health Law) and at Covington and Burling on programmatic issues; serving as a liaison between the Committee and its attorneys as necessary; community organizing; conducting site visits; designing public education strategies; extensive public speaking; working with the media; fundraising; and developing and managing student internships with local colleges and universities.

December 1983 to July 1986: **District Manager**
Department of Mental Health
Northampton, Massachusetts

Chief Executive Officer for five mental health and intellectual disability service areas (total population 800,000). Exercised responsibility for an approximately sixty million dollar budget. Overall responsibility for the implementation of the Brewster decree, a landmark Federal Court order governing the use of Northampton State Hospital and the development of community programs for people with mental illness. Responsibility for inpatient services at Northampton State Hospital until reorganization occurred. Extensive experience in working with organized labor, private provider agencies, local and state government officials, consumer and family advocates, the media and a wide spectrum of community groups interested in the mental health system and the implementation of necessary systemic reforms.

Management responsibilities also included planning; program development; program implementation; supervision of senior staff; community relations; dispute settlement; interagency coordination; budget preparation; oversight and monitoring; designation as appointing authority for all area-based state employees.

September 1983 to December 1983: **Director of Planning, Development and Compliance**
Belchertown State School
Belchertown, Massachusetts

Oversaw Belchertown State School's compliance with federal, state and court mandates; coordinated all responses and compliance plans for the court under the Ricci v. Greenblatt decree and for federal Medicaid. Worked with local and state officials and agencies on issues related to the present and future uses of state school property; developed long-range initiatives for the use of state school resources; designed and implemented tools, methods and techniques for monitoring service delivery at the State School; designed and implemented training in quality assurance for staff at all levels of the organization.

August 1982 to September 1983: **Acting Superintendent**
Belchertown State School
Belchertown, Massachusetts

Overall management responsibility for the direction of a large residential facility for individuals with an intellectual disability. Responsibilities included the implementation of a consent decree resulting from a federal class action lawsuit, Ricci v. Greenblatt. Management functions also included personnel authority over 1,400 staff; supervision of senior staff; oversight of budget preparation and spending for direct resources of over twenty eight million dollars in state and federal funds; labor relations; community relations; participation in the planning and implementation of community programs for clients with an intellectual disability in District I; and planning on statewide issues. Initiated the development of self-advocacy programs for the residents of Belchertown State School.

Worked as a primary member of the regional senior management team to plan and ensure the implementation of all necessary reforms in the provision of mental health and intellectual disability services to residents of Western Massachusetts and their families. Worked with senior management colleagues to design, coordinate and evaluate policies and program standards for all components of the systems in Western Massachusetts as mandated by two Federal Court ordered consent decrees.

October 1977 to August 1982: **Director of Employee Services**
Belchertown State School
Belchertown, Massachusetts

Responsible for the direct management and administration of all personnel, staff development and employee assistance programs. Responsible for labor/management activities including participation in state and national initiatives. Regional responsibilities included the development and support of staff development offices and programs. Co-investigator for a federal grant on training and manpower development from 1979-80.

Worked as a member of the regional management team responsible for the design, coordination and evaluation of staff development strategies for mental health and intellectual disability programs in Western Massachusetts as stipulated in two court ordered consent decrees.

April 1977 to October 1977: **Community Residential Services Consultant**
State of Georgia
Division on Mental Health and Mental Retardation
Atlanta, Georgia

Responsible for the statewide planning and monitoring of community residential services for people with an intellectual disability, including those with a dual diagnosis of mental

illness, particularly those in transition from institutional settings. Designed specific plans and processes for the placement of five hundred clients from state institutions throughout Georgia.

July 1976 to April 1977:

Advocacy Specialist
Advocacy Planning Project
Atlanta Association for Retarded Citizens
Atlanta, Georgia

Responsible for the statewide design and implementation of a protection and advocacy system for people with developmental disabilities as specified in Public Law 94-103. Activities included the planning and implementation of public hearings throughout Georgia.

July 1975 to July 1976:

Community Services Consultant
State of Georgia
Division of Mental Health and Mental Retardation
Atlanta, Georgia

Supervision of community services workers monitoring the placement of people with an intellectual disability who had returned to the Atlanta area from state institutions.

April 1974 to July 1975:

Cottage Life Supervisor
Georgia Mental Health Institute
Atlanta, Georgia

Supervisor of staff working in a transitional living unit for adults with an intellectual disability, including those with a dual diagnosis of mental illness, previously institutionalized in state facilities.

November 1973 to April 1974:

Assistant Teacher
Georgia Center for the Multihandicapped
Dekalb County Schools
Atlanta, Georgia

Assisted in the evaluation of school-aged children with multiple disabilities, including deafness and/or blindness. Assisted in the coordination of community-based services for these children in order to support their individual and family needs.

January 1971 to October 1971: **Editorial Assistant**
Department of Anthropology
University of Turin
Turin, Italy

Editing of manuscripts on primate classification. Editing and preparation of journal articles on genetics for the Academic Press, London. Teaching of English to graduate students at the University of Turin.

January 1969 to June 1970: **Board of Education**
Dayton, Ohio

Teacher of remedial class for seventh and eighth grade inner city children bused to suburban school to meet desegregation mandates.

CURRENT CONSULTATION

New York: Expert consultant for the Plaintiffs in Disability Advocates, Inc. v. Paterson, later refiled as O'Toole v. Cuomo, class action litigation brought on behalf of the residents of adult board and care homes in New York (June 2004-present).

Virginia: Expert consultant to the Independent Reviewer for the Settlement Agreement in United States v. Commonwealth of Virginia (July 2012-present).

North Carolina: Expert consultant to the Independent Reviewer for the Settlement Agreement in United States v. North Carolina (March 2015-present).

PAST CONSULTATION

Oregon: Expert consultant to the Independent Reviewer regarding compliance with the provisions of the Oregon Performance Plan (May-June 2018).

Puerto Rico: Assistant to the Court Monitor (January 2016). Under the supervision of the Court Monitor, assisted in the review of an outpatient mental health center previously under Federal Court supervision in Navarro v. Governor.

Maine: Consultant to the Court Master (August 2010 to 2015). Appointed Court Monitor by the Superior Court in order to document the funding for the adult mental health system and describe the impact of that funding on the Defendant's ability to achieve substantial compliance in Bates v. Harvey (August 2008-January 2010).

Consultant to the State Department of Health and Human Services regarding mental health services related to achieving compliance in the Bates v. Harvey case (February-June 2006).

Illinois: Expert consultant to the Court Monitor in Williams v. Quinn, class action case brought on behalf of individuals with mental illness who are confined to intermediate care nursing homes (October-December 2014). Expert witness to the Plaintiffs in Williams v. Quinn (February 2007-September 2010).

Texas: Member of the Monitoring Team reviewing compliance with the Department of Justice Settlement Agreement for Lubbock State Supported Living Center and Austin State Supported Living Center. Designated with expertise in protection from harm (November 2009-January 2013).

Expert consultant for the Plaintiffs in Lelsz v. Kavanagh, a class action lawsuit regarding the rights of individuals with an intellectual disability residing in institutions funded by the State of Texas (1991-1992).

Connecticut: Expert witness for the Plaintiffs in Messier v. Southbury Training School (September 2009-February 2010).

Virginia: Expert consultant to the Virginia Office of Protection and Advocacy regarding the death investigation of an individual confined to a state psychiatric hospital (November 2007-October 2008).

New York: Expert consultant to Touro Law Center in Rothenberg v. State, a case brought on behalf of an individual confined to a state psychiatric hospital (July 2004); Monaco v. Carpinelli regarding involuntary commitment evaluations (August 2006); and Sparks v. Seltzer regarding visitor restrictions on an inpatient ward (December 2006).

Paraguay: Expert consultant to Mental Disability Rights International on the reform of the mental health system in Paraguay. Action was taken pursuant to the Inter-American Commission on Human Rights' decision to grant precautionary measures regarding the Neuro-Psychiatric Hospital in Asuncion (2005-2010).

Kosovo: Expert consultant to Mental Disability Rights International for the development of a plan to assist the government of Kosovo in replacing the Shtime Institution with community based services/supports (November 2006-2007).

Bulgaria: In collaboration with Amnesty International and Mental Disability Rights International, expert consultant for the Bulgaria Helsinki Committee. Visited eight institutions for children and adults with an intellectual disability and/or mental illness in order to provide recommendations for systemic reform. Guest presenter at the Bulgarian Psychiatric Association's annual conference (October 2001-2002).

Massachusetts: Expert witness for the plaintiffs in Rolland v. Celluci. Case involved the right to habilitation for individuals with an intellectual disability/developmental disabilities confined to nursing homes (1999-2004).

Ireland: Guest lecturer to students/faculty at the Center for the Study of Developmental Disabilities, University College of Dublin, on contemporary issues in the field of intellectual disability 1999-2003).

Pennsylvania: Consultant for the Special Master in Halderman v. Pennhurst (May 1996-January 1997).

Romania: Consultant for Mental Disability Rights International on the development of services/supports for people with an intellectual disability (November 1995-1997).

District of Columbia: Expert consultant for the Department of Justice, Plaintiff-Intervenor in Evans v. Bowser, a class action lawsuit filed in Federal Court on behalf of individuals with a developmental disability institutionalized at Forest Haven (February 1995-May 1995).

Massachusetts: Expert consultant for the Defendants regarding the implementation of the consent decrees regarding the state schools (1992).

North Dakota: Consultant for the Protection and Advocacy System regarding systemic issues affecting individuals with mental illness institutionalized in state psychiatric facilities (1992).

Iowa: Expert consultant for the Plaintiffs in O'Connor v. Branstad, a class action lawsuit on behalf of individuals with an intellectual disability residing in two state schools (May 1989 to 1994).

New Mexico: Expert witness in Robbins et al. v. Budke, a class action case concerning access of the Protection and Advocacy System to a state hospital (December 1989).

Michigan: Expert witness in Kope v. Watkins, a class action lawsuit on behalf of individuals with an intellectual disability living in nursing homes (January 1989-1993).

Louisiana: Consultant to the Special Master in the Gary W. case in the New Orleans region (Spring 1986).

England and Wales: Consultant on the development of intellectual disability services for the Sheffield Health Authority, Manchester Health Authority and NINROD of Cardiff, Wales (October 1984).

PRIOR WORK IN OTHER LITIGATION

In Monaco v. Carpinelli, Sparks v. Seltzer, and Williams v. Quinn, I was deposed.

In Rolland v. Celluci, DAI v. Paterson and Messier v. Southbury Training School, I provided deposition and trial testimony. In Williams v. Quinn and O'Toole v. Cuomo, I testified at the Fairness Hearings.

In Robbins et al. v. Budke, I provided trial testimony.

DECLARATION OF DR. MARC STERN, MD MPH

On this 17th day of April, 2020, I hereby declare:

1. My name is Marc Stern. I am a board-certified internist specializing in health care for incarcerated populations. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections.

2. My experience includes the delivery of health care services to prisoners with serious mental illness and/or chronic medical conditions. The Washington State Corrections currently system has 19,000 prisoners. Each of its major institutions provides mental health services. Several of the facilities in the system deliver temporary or short-term in-patient psychiatric care for crisis management and stabilization. If higher level chronic mental health care is required, it is provided in specialized residential mental health treatment units.

3. I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University (Bloomington) in 1992. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

4. On a regular basis, I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts. My prior experience includes working with the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails.

5. Through 2013, I taught the National Commission on Correctional Health

Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course.

6. In the past four years alone, I have been qualified as an expert in several jurisdictions on correctional health care systems and conditions of confinement. My full *curriculum vitae* is attached hereto as Exhibit A.

7. I am not receiving payment in exchange for providing this affidavit to the Washington Lawyers' Committee for Civil Rights and Urban Affairs regarding appropriate healthcare measures during the COVID-19 pandemic for institutionalized populations. In light of the emergency conditions occurring in institutions across the country, I am providing my services *pro bono.*

8. I am familiar with the coronavirus that causes COVID-19 from a clinical perspective, including its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through congregate settings.

9. In the context of a pandemic like the one we currently face, public health and public safety interests are closely intertwined. When and if staffing challenges arise due to the need for staff to quarantine, seek treatment, or care for dependents, managing internal safety in institutional settings becomes even more challenging. Understaffing is dangerous for staff as well as institutionalized people.

10. I have reviewed the April 16, 2020 Amended Complaint in *Costa v. Bazron*,

No 1:19-cv-3185(RMD)(DDC) and the declarations of Danielle Mason, Ashley Guzman, Hadley Truettner, Penelope Donkar, William Dunbar, Enzo Costa, Vinita Smith, and Wanda Rose.

11. I have also reviewed the April 15, 2020 Mayor's Order 2020-063, Extensions of Public Health Emergency and Public Health Emergency and Measures to Protect Vulnerable Populations During the COVID-19 Public Health Emergency.

12. Assuming the facts described are true, the patients and staff at St. Elizabeth's Hospital are placed at an imminent and heightened risk from COVID-19 due to dangerous conditions, including but possibly not limited to: failure to ensure safe distancing between residents along with failure to provide them with masks, failure to provide adequate soap for hand hygiene, failure to place persons with suspected or proven COVID-19 infection in isolation or effective isolation, and failure to place persons who have had close contact with person suspected or proven to have COVID-19 in isolation in a timely manner.

13. Institutional settings are congregate environments where people live, eat, and sleep closely together. In these environments, infections like COVID-19 can spread more rapidly. Downsizing institutional populations serves two critical public health aims: (1) targeting residents who are at elevated risk of suffering from severe symptoms of COVID-19; and (2) allowing those who remain confined to better maintain social distancing and avoid other risks associated with forced communal living. Because vulnerable populations are at the highest risk of severe complications from COVID-19, and because when they develop severe complications they will be transported to community hospitals—thereby using scarce community resources (ER beds, general hospital beds, ICU beds)—avoiding disease in this population is a critical contribution to public health overall.

14. Thoughtful downsizing that weighs all the risks to the health of the individual as well as all risks the risks to public safety and public health, should be implemented in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts. Downsizing will help to "flatten the curve" overall—both within the institution and without. While prioritization should be given to those who are medically at-risk for complications of the virus, release of any individual contributes to reducing viral spread, as it is becoming clear that younger individuals are not protected from severe complications requiring hospitalization and placement in intensive care.

15. Downsizing of any congregate setting will reduce the risk of spread of virus. Given the aforementioned lapses in preventive measures, the value of downsizing is even greater.

16. At the same time authorities work to downsize the Hospital population where safe, it is critical that the D.C. Department of Behavioral Health immediately undertake or continue the following prevention and planning measures, some of which are not covered by the Mayor's Executive Order 2020-063:

a. **Implement guidance from the Center for Disease Control regarding Infection Prevention and Control (CDC) for COVID 19.** The D.C. Department of Health must continually update its practices to align with the current CDC guidance, modified, as necessary to account for local conditions..

b. **Immediate testing.** Patients who require testing, based on public health recommendations and the opinion of a qualified medical professional, should be tested for COVID-19.

c. **Immediate screening.** Authorities must be required to screen each employee or other person entering the facility *every day* to according to current CDC or local health

department guidelines A record should be made of each screening.

d. **Quarantine and Isolation.** The Hospital must establish clinically effective quarantine for all individuals believed to have been exposed to COVID-19, but are not yet symptomatic, and clinically effective isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely infected with COVID-19 must utilize protective equipment, including masks, as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the confined population. Once individuals have been potentially infected, they should be quarantined for an appropriate period of time and during that time period no new individual should be added to the quarantined cohort. Individuals requiring continued quarantine, isolation, or health care after release should be transferred from the institution to the appropriate outside venue.

e. **Institutional Hygiene.** The Hospital must be required to provide adequate sanitation of high use/high touch areas and rooms and bathrooms in accordance with CDC or local health authority guidelines. This includes a prompt way to dispose of tissues used by patients as well as staff.

f. **Personal Hygiene.** The Hospital must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis. Hospital staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol – under supervision if necessary – when they are in locations or activities where hand washing is not available.

g. **Access to treatment.** It is critical that patients have rapid access to responsive medical treatment. Those with a cough should be provided masks as soon as they inform staff of this symptom or staff notice this symptom.

17. The measures I propose above are baseline steps to help slow the spread of COVID-19 in all facilities. However, each facility has its own unique combination of physical structure and layout, operations, policies, logistics, inmate characteristics, and staffing factors that determine what additional measures may be necessary to minimize the spread of COVID-19. Only a health expert who is able to review a particular facility firsthand can account for all of those factors and provide a meaningful and facility-specific opinion about what additional measures are necessary to reduce the risk of transmission.

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

Executed on April 17 2020

Marc Stern, MD MPH

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

April, 2020

marcstern@live.com
+1 (360) 701–6520

SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

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

REVIEWER/EDITOR

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

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

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

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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EXPERT TESTIMONY

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

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

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

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

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

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

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

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of April 2, 2020, there are over 800,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 45,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States in regions like New York, New Jersey, Louisiana, Michigan and Illinois.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

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

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.

7. When a community or institution lacks a comprehensive and rigorous testing regime, a lack of proven cases of COVID-19 is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.

8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

10. There is no cure and vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

12. In early March, the highest known person-to-person transmission rates for COVID-19 were in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. More recently, the highest transmission rates have been recorded in the Rikers Island jail complex in New York City, which is over seven times the rate of transmission compared to the spread in New York City. To illustrate, the number of confirmed cases among inmates soared from one to nearly 200 in the matter of 12 days.

13. This is consistent with the spread of previous viruses in congregate settings. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to

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

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

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

Dr. Jonathan Louis Golob

DECLARATION OF HADLEY TRUETTNER
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

I, Hadley Truettner, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Hadley Truettner. I make these statements based upon my personal knowledge.
2. I am a staff attorney in the Mental Health Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since January of 1995. PDS is a federally funded, independent organization dedicated to representing indigent adults and children facing the loss of liberty in the District of Columbia. My principal responsibilities as a staff attorney at PDS are to represent both persons facing civil commitment and persons committed to the Department of Behavioral Health as a result of a not guilty by reason of insanity finding.
3. In the course of my work, I regularly speak to clients who are admitted to locked psychiatric wards in area hospitals, including Psychiatric Institute of Washington, United Medical Center, Washington Hospital Center and the Veteran's Affairs Medical Center and Saint Elizabeths Hospital (hereinafter "SEH"), their family members, their guardians, and their treating doctors and treatment teams. Through those conversations, I learned the following:

   > During an April 9, 2020 email correspondence with a social worker in an area hospital, I learned my client's treatment plan is to be transferred to Saint Elizabeths Hospital for long term care. Surprised that Saint Elizabeths would be accepting clients given the COVID-19 outbreak at the hospital, I inquired whether Saint Elizabeths is really accepting new patients. The social worker responded, "They are accepting patients."

4. In a follow up email to Dr. Philip Candilis, Director of Medical Affairs at Saint Elizabeths Hospital on the morning of Friday, April 10. I explained that I have a client in an area hospital whom that hospital intends to transfer to Saint Es. I inquired as follows:

   > "The social worker [from the area hospital] indicated that Saint Es is accepting patients. Can you confirm? Thanks very much."
   >
   > Dr. Candilis responded later that morning: "Yes, confirmed."

5. On April 13, 2020, I had a conversation with a different social worker at the same area hospital regarding another client's long-term plan. The social worker indicated that my client will be transferred to Saint Elizabeths. I wrote the following question:

   > "Is Saint Es currently taking folks?"

> The social worker responded, "Yes its [Saint Elizabeths] moving slowly but they are currently accepting."

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

Executed on the 16th day of April 2020 in Washington, D.C.

Hadley Truettner

_____

Hadley Truettner
Staff Attorney
Public Defender Service, MHD
633 Indiana Avenue Ave, NW
Washington DC 20004

DECLARATION OF ENZO COSTA
PATIENT AT SAINT ELIZABETHS HOSPITAL

I, Enzo Costa, *certify under penalty of perjury that the following statement is true and correct.*

1. I am thirty-eight years old and a patient at Saint Elizabeth's Hospital in Unit 1C. I am diagnosed with schizophrenia, dystonia, schizo-affective disorder, and anti-social personality disorder. I am indefinitely, involuntarily civilly committed to the District's care.

2. I first became aware of the COVID-19 pandemic from the news and then it was discussed in the Patient Advisory Committee meetings at St. Es.

3. My Unit, Unit 1C, currently houses thirteen men who are institutionalized at St. Es for pre-trial competency evaluations and restoration.

4. On about April 1, 2020 we were advised to remain in our Unit at all times due to COVID-19. Patients in my Unit all use the same common spaces, including the dining hall, laundry room, and lounge. It is impossible for me to maintain six feet of distance between myself and other patients in my Unit.

5. Patients in my Unit are going to the dining room in groups of two or three. Even with these limited numbers, there is not enough space for us to maintain six feet of distance from other patients during meals.

6. One patient in my unit is symptomatic for COVID-19. He is self-quarantining in his room but is still on the Unit.

7. The staff in my Unit are not all wearing masks and gloves.

8. I have been wearing a mask almost all of the time because I am afraid that patient and other patients in my Unit have COVID-19.

9. I normally receive group therapy including competency restoration and anger management. I have not received any group therapy or remote substitute for the past few weeks.

10. I also normally receive individual therapy but I haven't received any individual therapy or remote substitute in the past few weeks.

11. None of the patients on my unit have had access to religious ceremonies, even remotely, for the past few weeks.

12. I have a toothache but there are no dental services being provided right now.

13. To my knowledge, there is no on-site testing for COVID-19 at the hospital. I have not been tested for COVID-19.

I, Stephanie Maldonado, certify that I have read the foregoing to Mr. Costa and that he affirmed that the foregoing is true and correct on April 17, 2020.

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

Executed on April 17, 2020.

Stephmaldonado

Stephanie Maldonado

DECLARATION OF WILLIAM DUNBAR
PATIENT AT SAINT ELIZABETHS HOSPITAL

I, William Dunbar, *certify under penalty of perjury that the following statement is true and correct.*

1. I am forty year old and a patient at Saint Elizabeth's Hospital in Unit 2A. I am diagnosed with paranoia schizophrenia. I am indefinitely, involuntarily civilly committed to the District's care.

2. I first became aware of the COVID-19 pandemic from the news and my family.

3. My Unit, Unit 2A, houses up to twenty-seven men who are classified as Not Guilty by Reason of Insanity.

4. On about April 1, 2020 we were advised to remain in our Unit at all times due to COVID-19.

5. Until April 15, 2020, all of the patients on my Unit were subjected to the following conditions:

    a. Four patients on my Unit tested positive for COVID-19. Two of them were moved to the quarantine unit on the second floor but two of them remained in my Unit with the rest of us who were asymptomatic and potentially unexposed patients.
    b. The COVID-19 positive patients were interacting with us in the common areas where they watch television or got water. Patients in my Unit all use the same common spaces, including the dining hall, laundry room, and lounge.
    c. I had my own room, but there are men on my Unit who shared a room with another patient.
    d. We were given a limited number of masks and were not given instruction on how to wear it properly. I was only given one mask by St. Es staff.
    e. My Unit was short-staffed. I learned from the news that at least one nurse who works on my unit regularly has been admitted to Howard Hospital's Intensive Care Unit with COVID-19.

6. As of April 15, 2020, the St. Es separated the patients in my Unit. Those of is that are not symptomatic for COVID-19 are now being housed in the gym. We were not tested for COVID-19 before being moved to the gym.

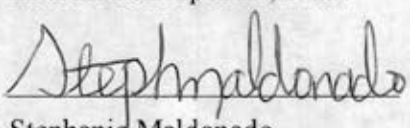
7. I usually receive group therapy. I have not received group therapy or a remote substitute for the past few weeks.

8. To my knowledge, there is no on-site testing for COVID-19 at the hospital.

I, Stephanie Maldonado, certify that the foregoing was read to Mr. Dunbar and that he affirmed that the foregoing is true and correct on April 17, 2020.

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

Executed on April 17, 2020.



Stephanie Maldonado

DECLARATION OF VINITA SMITH
PATIENT AT SAINT ELIZABETHS HOSPITAL

I, Vinita Smith, *certify under penalty of perjury that the following statement is true and correct.*

1. I am fifty-seven years old and a patient at Saint Elizabeths Hospital in Unit 1F. I am diagnosed with schizo-affective disorder that requires medication and therapy. I am indefinitely, involuntarily civilly committed to the District's care.

2. I first became aware of the COVID-19 pandemic from the news.

3. The Hospital created a quarantine Unit on the second floor.

4. My Unit, Unit 1F, houses up to 27 women. I have a single room, but other patients in my Unit are residing in a room with another patient.

5. On about April 1, 2020 we were advised to remain in our Unit at all times due to COVID-19. Patients in my Unit all use the same common spaces, including going to the dining hall in groups of 10, using the same laundry room, and using the same lounge.

6. It is impossible for me to maintain six feet of distance between myself and other patients in my Unit.

7. We have access to soap, which runs out frequently.

8. No one on my Unit has been tested for COVID-19 that I know of.

9. No one at Saint Elizabeths has provided me with a mask or instructed me on how to properly wear a mask.
10. I have only received two session of remote therapy via telemedicine in the last two weeks.

11. To my knowledge, there is no on-site testing for COVID-19 at the hospital. I have not been tested for COVID-19.

I, Stephanie Maldonado, certify that the foregoing was read to Ms. Smith and that she affirmed that the foregoing is true and correct on April 17, 2020.

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

Executed on April 17, 2020.

Stephanie Maldonado

DECLARATION OF ASHLEY GUZMAN
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

I, Ashley Guzman, certify under penalty of perjury that the following statement is true and current pursuant to 28 U.S.C § 1746.

1. My name is Ashley Guzman. I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Mental Health Division at the Public Defender Service for the District of Columbia and have served in this role since April 2015. PDS is a federally funded, independent organization dedicated to representing indigent adults and children facing the loss of liberty in the District of Columbia. My principal responsibilities as a staff attorney at PDS are to represent both persons facing civil commitment and persons committed to the Department of Behavioral Health as a result of a not guilty by reason of insanity finding, and to consult with attorneys in various other divisions of PDS as a mental health litigation specialist.

3. In the course of my work, I regularly speak to clients who are committed to Saint Elizabeths Hospital (hereinafter "Hospital"). Specifically on April 15, 2020, I spoke with clients at the Hospital and through those conversations, I learned the following:

    a. I learned about conditions on Unit 2TR of the Hospital. I learned that Unit 2TR was originally designated as the Hospital's quarantine unit. All patients on the unit tested positive for COVID-19. There are only seven patient beds on the unit. However, once COVID-19 spread throughout nearly all of the other units in the Hospital, at least one COVID-19 positive and symptomatic patient was transferred to another unit in the Hospital. The receiving unit houses patients who have not tested positive for COVID-19. Regarding the conditions of Unit 2TR, I learned that all patients were provided with masks, but no other personal protective equipment. Patients were given new masks every day. All staff wore masks and full protective suits. Bottles of hand sanitizer were provided to patients. The patients were housed in their own rooms with their own bathrooms. The bathrooms were stocked with hand soap. Staff did the patients' laundry once per week. The common areas of Unit 2TR were sanitized daily, but the patients' bedrooms and bathrooms were not. Patients had to request to have their bedrooms and bathrooms sanitized. Patients were not provided with any cleaning materials to clean their own bedrooms and bathrooms. Staff in full personal protective gear delivered all meals and medications to the patients' individual bedrooms. During the day, patients were restricted to their rooms, but were allowed to go to Unit 2TR's balcony once per day for up to thirty minutes. Staff permitted only one patient on the balcony at a time.

    b. I learned about the conditions on Unit 2B of the Hospital. I learned that there are about 27 patients on the unit. Some of the patients on Unit 2B have tested positive for COVID-19, but not all. Not all of the patients have masks to wear. As of April 15, 2020, there were at least four patients without masks on the unit

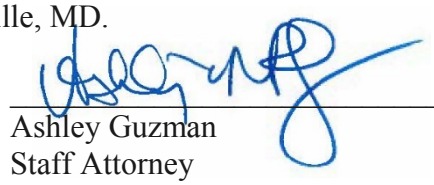
due to a mask shortage. Patients are provided new masks only every three days. All staff on Unit 2B wear masks at all times, but no other personal protective equipment. Unlike Unit 2TR, the patients are not provided with bottles of hand sanitizer. There is hand sanitizer behind the nurse's station, but the patients have to approach the station to ask for sanitizer. There are a couple of hand sanitizer dispensers on the unit, but the dispensers are often low on sanitizer. On Unit 2B, patients have to do their own laundry on specific days. However, the laundry room remains locked at all times, and often patients miss their days to do their laundry. The common areas of Unit 2B are sanitized daily, but the patients' bedrooms are not. The patients are not provided with cleaning material to clean their own rooms, and must request to have their rooms sanitized. There are at least three bedrooms with two patients in each room. All meals are served in the unit cafeteria. There is supposed to be a limit of 10 patients in the cafeteria at a time, but when there are new staff members on the unit, this rule is not enforced. On the morning of April 15, 2020, new staff members allowed more than 10 people in the cafeteria to dine. There is supposed to be a limit of two patients per table, but on the morning of April 15, 2020, staff allowed at least four patients per table. Since the COVID-19 outbreak, staff are allowing patients to eat meals in the common area. In order to receive medication, the patients must approach a medication window and receive medication from staff. During the day, COVID-19 positive patients are not allowed to utilize off-the-unit privileges, but they are allowed to freely walk around the unit and watch television in the common areas. Patients who are not symptomatic and/or have not tested positive for COVID-19 are permitted to watch television in the common area and share a couch with COVID-19 positive patients. Staff members are not enforcing social distancing during the day.

c. I learned about the conditions on Unit 2C of the Hospital. I learned that during the week of April 6, 2020, at least one patient presented with cold-like symptoms, but that patient was not tested for COVID-19. I learned that none of the patients on Unit 2C had been tested for COVID-19. The patients are not required to wear masks. If a patient asks for a mask, and if a mask is available, the staff will provide the patient with a mask. The patients are not provided with any other personal protective equipment. All staff members wear masks every day, but most do not wear any other personal protective gear. Some staff members wear gowns. Hand sanitizer is only available behind the nurse's station desk, and patients have to approach the nursing station to request sanitizer. There are no hand sanitizer dispensers on Unit 2C. The patients on Unit 2C share bathrooms. I learned that often at least two days go by before the staff realize that there is no handsoap in the bathroom. The patients on Unit 2C must do their own laundry or designated days, and must request that the laundry room be unlocked in order to do laundry. The common areas of the Unit 2C are sanitized daily, but the patients' bedrooms are not. The patients must request to have their bedrooms sanitized, and are not provided with cleaning material to clean their own bedrooms. At least three of the bedrooms on Unit 2C have two patients in each room. Meals are served either in the dining room or in the common area of the

unit. Eight patients are allowed in the dining room at a time, and two patients are allowed per dining table. When patients dine in the common area, social distancing is not enforced. Due to the number of patients on the unit, and the size of the unit, keeping six feet away from other patients is nearly impossible on the unit. Patients gather on the couches to watch television together. Some patients are presenting with coughing symptoms, but they are not restricted to their rooms. Medication is administered at a medication window, and 3-4 people line up at a time to receive their medication. There are no distancing requirements in the medication line.

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

Executed on this 16th day of April 2020, in Hyattsville, MD.



Ashley Guzman
Staff Attorney
Public Defender Service for DC
633 Indiana Avenue NW
Washington, DC 20001

DECLARATION OF WANDA ROSE
PROGRAM DEVELOPER AT THE PUBLIC DEFENDER SERVICE

I, Wanda Rose, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Wanda Rose. I make these statements based upon my personal knowledge.

2. I have a Masters in Forensic Psychology and I work as a program developer in the Mental Health Division at the Public Defender Service for the District of Columbia (hereinafter "PDS"). I have served in this role since September 21, 2003. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a program developer at PDS is to assist attorneys in my division with the social work aspects of their cases.

3. As part of my duties as a program developer at PDS, I regularly speak to clients who are pending civil commitment proceedings and those who are committed at St. Elizabeths Hospital ("SEH").

4. On April 15, 2020, I spoke to Client A, at SEH on the ward 1-G.

5. From this conversation I learned the following:

Client A had heard that nine people throughout SEH were COVID-19 positive. Client A had not heard of anyone on their ward being positive, and was not aware of anyone being in quarantine. All patients are confined to the ward.

Client A indicated that the safety protocols are inconsistently followed. Masks are available to patients on the ward; however patients have to request them. Some of the SEH staff are wearing them, some are not. Some patients are wearing them, some are not. They are not required. Client A said that some people don't like the masks, so they do not wear them. Patients can get a new mask but they must request one. Client A said some of the masks are homemade, and they have seen SEH staff making masks out of pajamas. Some staff are wearing gloves, some are not. Client A said that if a staff is going to give something (i. e., gloves, mask, medication) to a patient, the staff will put on gloves to do this. Client A said no staff are wearing gowns of any kind.

Client A indicated that cleaning seemed adequate. Soap and hand sanitizer are available upon request. Laundry services are available for patients to use during the day. Client A said the ward is professionally cleaned twice weekly. Patients are given supplies upon request and are able to clean their own rooms.

Client A indicated that social distancing is inconsistently practiced. Patients are allowed out of their rooms. Patients are still congregating in the common areas (i. e., the TV room) of the ward, with inadequate room for social distancing. Medication is still being given out at the

nurses' station, with patients lining up and limited room to social distance. Client A said they wait to get their own medication until everyone else has already gotten theirs, so they don't have to wait in the line. Meals are still in the dining room on the ward. Patients are limited to two individuals per table, down from the usual four per table. Tables have been moved to six feet apart.

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

Executed on the 15th day of April 2020, in North Beach, Maryland.

Wanda Rose

_____

Program Developer
Public Defender Service for DC
633 Indiana Ave. NW
Washington, DC

DECLARATION OF DANIELLE MASON
FORENSIC PROFESSIONAL COUNSELOR AT THE PUBLIC DEFENDER SERVICE

I, Danielle Mason, *certify under penalty of perjury that the following statement is true and correct pursuant to* 28 U.S.C. § 1746.

1. My name is Danielle Mason. I am a licensed professional counselor in the District of Columbia. I make these statements based upon my personal knowledge.

2. I am a forensic professional counselor in the Mental Health Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since August 20, 2018. PDS is a federally funded, independent organization dedicated to representing indigent adults and children facing loss of liberty in the District of Columbia.

3. As part of my duties as a forensic professional counselor at PDS, I frequently conduct visits and maintain regular contact with clients in the custody of St. Elizabeth's Hospital.

4. During the pandemic, I have spoken to clients. Through those conversations, I learned the following:

   a. On April 15, 2020, I spoke with Client A at St. Elizabeth's Hospital, unit 2C. While masks are available, I learned that patients must ask for one from staff and some patients do not wear masks. New masks are provided to patients when they ask; although, never more than once per day. Staff are wearing masks, but I learned that some of the masks appear to be homemade. Staff on 2C have not been wearing gowns, or other personal protection equipment, since April 13, 2020. I learned that patients must ask staff to use hand sanitizer. I learned that the patients of 2C eat meals in the dining room and day room. All patients eat at the same time. Approximately 10 patients can eat in the dining room; the remainder eat in the day room. Most patients try to sit six feet apart, but one of the tables is set up in such a way that causes two patients to be back-to-back. I learned that patients spend most of their days in their bedrooms or in the day room. Some patients continue to play Wii video games, watch television in close quarters and sleep on the couch in the day room. I learned that medications on 2C continue to be administered from the medication room. Patients line up shoulder–to-shoulder three times per day to receive their medications.

   b. On April 15, 2020, I spoke with Client B at St. Elizabeth's Hospital, unit 2A. There are approximately 27 patients assigned to 2A. 2A patients presumed to be negative for COVID-19 will moved off the unit and into the gymnasium today. I learned that patients on 2A are provided with masks, which were described as paper thin and easily tear. I learned that patients do not have access to hand sanitizer, but there is soap in the bathroom. Housekeeping wipes down the unit approximately twice daily. Client B could not recall the last time that patient bedrooms were cleaned by housekeeping. I learned that patients on 2A eat in the dining room. Approximately eight patients are allowed to eat at one time and eating times are staggered. I learned that patients on 2A continue to receive medications from the medication room. Patients are encouraged to stand six feet apart, but often do not. I learned that patients with pending COVID-19 test results are not confined to their rooms and their

movements are not restricted on the unit.

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

Executed on the 15th day of April 2020, in Washington, D.C.

Danielle Mason
Forensic Professional Counselor
Public Defender Service for DC
633 Indiana Ave. NW
Washington, D.C.

DECLARATION OF PENELOPE DONKAR
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

I, Penelope Donkar, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is Penelope Donkar. I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Mental Health Division (hereinafter "MHD") at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since June 2015. PDS is a federally funded, independent organization dedicated to representing indigent adults and children facing the loss of liberty in the District of Columbia. My principal responsibilities as a staff attorney at PDS are to represent both persons facing civil commitment and persons committed to the Department of Behavioral Health as a result of a not guilty by reason of insanity finding

3. In the course of my work, I regularly speak to clients who are committed to Saint Elizabeths Hospital (hereinafter "Hospital"), their guardians, and their treating doctors. Through those conversations, I learned the following:

    a. Client A is an individual in care at St. Elizabeths Hospital. On April 11, 2020, I received a voicemail from Client A indicating that client was being admitted to a medical hospital with a fever. On Monday April 13, 2020, a physician at Georgetown Hospital contacted PDS for Client A's guardian's contact information. The physician indicated that the guardian's contact information was not sent by St. Elizabeths with Client A. Additionally, St. Elizabeths had not contacted Client A's guardian to inform him that Client A was suspected of having COVID-19, that client had been exposed to COVID-19 on the unit, or that client was being admitted to a medical hospital with COVID-19. St. Elizabeths also did not inform me about Client A's medical status despite a properly executed HIPAA waiver previously on file.

    b. Client B is an individual in care at St. Elizabeths Hospital. Client B is currently inpatient civilly committed. Client B was tested for COVID-19 last week. Following that test, the treatment team refused to provide information about Client B's COVID status despite a properly executed HIPAA waiver. Client B's guardian was not notified of the COVID-19 status of the unit or that Client B was being tested for COVID-19. Guardian discovered the existence of COVID-19 at St. Elizabeths after talking with the guardians of other individuals.

    c. Client C was a patient on Unit 1B of St. Elizabeths. On Monday, April 6, 2020, I learned that my client, Client C, had been sent to George Washington University Hospital with symptoms of COVID-19 when I attempted to set up a video conference with him. At that time, he was awaiting COVID-19 test results. Despite having an executed HIPAA waiver for Client C, the treatment team did

not give me updates regarding Client C's status. I did not receive an update about Client C until I received notice on April 10, 2020 that Client C had died at GWUH.

4. I have been attempting to track the status and location of MHD's clients who have tested positive while at St. Elizabeths. Doing so has been difficult because Hospital staff has often refused to provide updates or disclose basic information about our clients upon request, even when there was a properly executed HIPAA waiver. Of the 18 MHD clients that I have identified as being positive or presumptively positive, it is my understanding that 11 still remain on various units at the Hospital.

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

Executed on the 17th day of April 2020 in Washington, D.C.

_____

Penelope Donkar
Staff Attorney
Public Defender Service for DC
633 Indiana Avenue NW
Washington, DC 20001