STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

WAYNE COUNTY JAIL INMATES, et. al.,

Plaintiffs,

v

WILLIAM LUCAS, et. al.,
Defendants.

Case No. 71 173 217 CZ

Hon. Timothy M. Kenny

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Index of Exhibits to Plaintiffs' Emergency Motion for Temporary Restraining Order and Preliminary Injunction

EXHIBIT	**DESCRIPTION**
1	Report of the Inspection of the Wayne County Jail on May 16, 2020 by Fred Rottnek, MD, MAHCM
2	Complaint, *Russell et al., v. Wayne County et al.*, No. 2:20-cv-11094-MAG-EAS, ECF No. 1 (E.D. Mich. May 4, 2020)
3	Declaration of Dr. Marc Stern (Ex.1 in *Russell* Complaint)
4	Declaration of Dr. Jaime Meyer (Ex.2 in *Russell* Complaint)
5	Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities CDC.gov (Ex.7 in Russell Complaint)
6	Declaration of Dr. Adam Lauring (Ex.14 in *Russell* Complaint)
7	Declaration of Courtney White
8	Declaration of Mark Matthews
9	Declaration of Charles Russell
10	Declaration of Terri Nickel
11	Declaration of Dominick Kelly
12	Declaration of Carl Smelley

13 Declaration of Shane Carline

14 Declaration of Shokelle McKay

15 Declaration Marlon Blanks

16 Declaration of Christopher Hubbard

17 Declaration of CalDerone Pearson

18 Declaration of Mark Malec

19 Declaration of Harry White

20 Declaration of Davonte Velez

Wayne County Jail Inspection Report
May 16, 2020
Fred Rottnek, MD, MAHCM

1. **Executive summary** My recommendations include
    a. Continue reducing the population in all three facilities as quickly as possible, so that medically vulnerable populations have fewer exposures to potentially deadly coronavirus and social distancing measures can be better followed by those remaining in physical custody.
    b. Follow the Centers for Disease Control and Prevention (CDC) Interim Guidance on the Management of Coronavirus Disease 201(COVID-19) in Correctional and Detention Facilities, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html
    c. Increase regular and as-needed testing for COVID-19 infection for inmates, staff, and any other visitors.
    d. Post and distribute to all stakeholders up-to-date education about prevention, spread, and treatment of COVID-19. This information should also include the definitions and importance of social/physical distance, and the use of personal protective equipment (PPE).
    e. Post schedules for cell and common space cleaning with CDC-approved disinfectants that kill coronavirus.
    f. Adjust medical services to meet the demand of this population during the pandemic. Stop disincentivizing inmates from sick call and seeking assistance.
    g. Provide aftercare planning to inmates so that they are aware of practices to safely return to their homes and communities, since many have been exposed to COVID-19.
    h. Discontinue housing inmates and staffing of workers in the secured areas of Division II as soon as possible. This environment is unsafe for more reasons than COVID-19.
    i. If these measures are not adopted, this jails will continue to be an ongoing source of infection, morbidity, and mortality to all residents of Wayne County.

2. I would like to thank all the members of the Sheriff Napoleon's office as well as Corporation Counsel for their assistance in the tours, the opportunity to interview inmates in an unhurried manner, and the information they provided me during this inspection. A special thank you to Sergeant Elon who was with us all day to take photos and provide information regarding the system.

3. **Materials reviewed before finalizing inspection reports**
    a. The Joint Proposed Inspection Order, ordered by Chief Judge Timothy M. Kenny
    b. Centers for Disease Control and Prevention (CDC) Interim Guidance on the Management of Coronavirus Disease 201(COVID-19) in Correctional and Detention Facilities, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html This is my primary resource.
    c. Additional resources include
        i. The United States Department of Justice National Institute of Corrections' NIC Coronavirus Information, https://nicic.gov/coronavirus
        ii. National Commission on Correctional Health Care's COVID-19 Coronavirus: What You Need to Know in Corrections, https://www.ncchc.org/COVID-Resources

4. **Individuals interviewed** during this inspection include
    a. Individual staff in the Sheriff's office, who also conducted the tours of the facilities
    b. Medical staff in Division I and II
        i. Division I
            1. Psychiatric Nurse Practitioner, Dr. McCauley
            2. Nurses/techs passing medications
        ii. Division II
            1. Nurse Coleman
    c. Inmates in all 3 Divisions
        i. Division 1
            1. Psychiatry floor
                a. Lemar Stanley
                b. Damasi Cook
            2. Women's floor
                a. Rhionna Nichols
                b. Christiana Carey
            3. Quarantine unit
                a. David Ellecchia
                b. Corey Sims
                c. Robert Littmer
                d. Sean Willis
                e. Robert Moran
        ii. Division II
            1. General population
                a. Deangelo Butts
                b. Barius Robison
                c. Christopher Moore
                d. Omar Taylor
                e. Murray Stuart

f. Darnell Moore
g. James McCoy
h. Marcus Lynn
i. Anthony Childs
j. Jason Bell
k. Jason Childs
l. Sylvester Cornelius
m. James Matthews
n. David Grier
o. Michael Beeve
p. Delano Marquez

2. 4th floor (COVID positive/suspected floor)
    a. Aaron Davis
    b. Joshua Brown
    c. Craig Gullege
    d. Darrel Smith
    e. Damon Bailey
    f. Steve Williams
    g. Cornelius Barnes
    h. Kyle Dyas

iii. Division III

1. General population
    a. Marcus Russel
    b. Derrick Houston
    c. Ray Culbertson
    d. Mika Simpson
2. COVID+ unit
    a. Ariel Sunday
    b. Darron Thomas
    c. Deandre Paul

5. **Observations for Divisions I, II, and III** regarding matters related to below
    a. Conditions of the housing units during the COVID-19 pandemic
        i. Division I:
            1. Building is in some disrepair, with uneven floor and missing tiles
            2. All cells outside of medical unit have front facing walls of bars or open steel grids. This allows aerosolized and large droplets containing COVID-19 to be freely spread from cells, where inmates are not wearing masks.
            3. Toilets and sinks are located near the front wall of these cells. They have no lids. COVID-19 can be aerosolized from fecal matter—whether from the act of voiding or flushing a toilet.
            4. The cells appear to be clean, but many of them are cluttered.

ii. Division II:
    1. Building is in severe disrepair.
    2. All cells outside of medical unit have front facing walls of bars. This allows aerosolized and large droplets containing COVID-19 to be freely spread from cells, where inmates are not wearing masks.
    3. Toilets and sinks are in each cell. They have no lids. COVID-19 can be aerosolized from fecal matter—whether from the act of voiding or flushing a toilet.
    4. There is extensive rusting, paint chipping, and filth on bars, heaters, and other horizontal surfaces.
    5. Vents in cells are usually at least partially blocked by dirt and airborne dust.
iii. Division III
    1. House units appear clean.
    2. Doors are solid surface, so transmission of the virus is mitigated when an inmate is in his room.
    3. Toilets and sinks are located near the front wall of these cells. They have no lids. COVID-19 can be aerosolized from fecal matter—whether from the act of voiding or flushing a toilet. Aerosolized particles can remain in the air for several hours.
    4. The cells appear to be clean, but many of them are cluttered.

b. Conditions of and access to shower/bathroom facilities during the COVID-19 pandemic
    i. Staff reported that the County provides bleach and Simple Green for cleaning
        1. **Simple green does not kill COVID-19,** https://simplegreen.com/news-and-media/coronavirus-faq/
        2. Diluted bleach is effective in killing COVID-19.
    ii. Division I
        1. Medical unit: The shared room which I inspected has a shared bathroom which is usually cleaned once/day by a trustee. It should be cleaned after each use.
    iii. Division II
        1. Individual cells have toilets and sinks. Units share a shower. Inmates demonstrated for me that water pressure is low, and they reported little to no hot water.
        2. The showers on the floors have extensive rust and chipping and peeling paint on ceiling and walls. (Photo) It appears the black mold or mildew flows from the buttons controlling water flow.
    iv. Division III
        1. Inmates have access to the shower/bathroom facilities when needed—one unit is a wet unit (with sink/toilet in room); the

other is a dry unit (without sink/toilet—they are communal, at the far end of the unit).
2. Tiles are missing in shower
3. Rust and mildew are present on bathroom fixtures and walls

c. Conditions of and access to medical, laundry, dining facilities and shared common areas during the COVID-19 pandemic
   i. Division I
      1. Medical: Rooms appear clean, but cluttered. Some inmates stated that they are getting their medical needs met. Others stated the that virus has slowed down responsiveness to their sick calls. According to the two officers sitting in an otherwise empty clinic, they were unable to give clinic hours or rough capacity at present. They stated that they have been understaffed with providers recently, but they just got a new physician. (When we walked in, they were sitting at their desk, shoulder-to-shoulder, about a foot apart, and they were not wearing
      2. Laundry: Linen exchange area appeared clean
      3. Dining facilities: There is currently no shared dining for trustees. In all facilities, inmates are eating in their rooms by themselves.
      4. Kitchen: The kitchen area is large and appeared clean, but it had many wet surfaces. The kitchen supervisor stated that “we can’t clean like we’re supposed to” because she used to have 25-28 trustees for cleaning and now only has 2. She reports that they “clean daily”.
      5. Shared common areas: Appear clean. Two of the three men’s units I visit were on 23-hour lockdown. In the women’s unit, woman have more time in the common area.
   ii. Division II
      1. Medical: The medical care as reported was almost wholly inadequate. Nurse Coleman stated her biggest concern was the movement of inmates among units. She wondered why “inmates [are] still here?” When I asked her if she thought they were adequately staffed in medical with COVID as well as chronic care and sick calls, she stated “Not really, to be honest, due to the shortage [of staffing].”
         Patients report delayed or ignored sick calls.
      2. Laundry: No laundry is done at this facility, but it is shipped to Division III. Some inmates stated that they are not getting fresh linen every week. One stated he’s had the same uniform for 6 weeks.
      3. Dining facilities: Inmates eat in their rooms.

4. Kitchen: Not visited in this building
5. Shared common rooms: These areas are common areas that each cell releases into. There is extensive rusting, paint chipping, and filth on bars, heaters, and other horizontal surfaces.

iii. Division III

1. Medical: Appears clean. Three or four nurses and/or tech were present for sick calls and med passes.
2. Laundry: The laundry was empty on this Saturday tour. It appeared clean.
3. Dining facilities: All inmates eat in their cells.
4. Kitchen: Appeared clean, but little activity at the time
5. Shared common areas: Appeared clean, and only one inmate is allowed out at the time. While I was there, 3 or 4 trustees were present to wipe down surfaces. Inmates report that telephones are not wiped down between use.

d. Availability and stock of cleaning supplies and personal protective equipment for inmates and jail staff

i. I did not explicitly ask to see stocks of cleaning supplies, hygienic supplies, or PPE, so I did not see the inventories. I apologize for this oversight.

ii. Of concern, none of the staff at all three sites knew how to don the blue plastic protective suits.

iii. There was inconsistent use of masks, and the appropriate wearing of masks, among both inmates and staff.

iv. Answers varied widely when I asked inmates if they had enough cleaning supplies. Some said they did; others said they frequently were told that the inventory was low or zero.

v. Division I

1. PPE and cleaning supplies were seen in the kitchen, the laundry, the clinic, the medical unit, and at the officers' stations.
2. I saw one two-man team of trustees emptying the trashcans in on of the quarantine units. Otherwise, I saw no one cleaning any area during my visit.

vi. Division II

1. PPE and cleaning supplies were seen in the clinic and at the officers' stations.
2. I observed a few buckets with mops in shared areas. I saw several unused buckets and mops in an unused cell in an empty block.
3. Inmates frequently reported lack of supplies
4. I saw no inmates cleaning any area during my visit.

vii. Division III
    1. As mentioned, I saw a group of 3-4 trustees cleaning the first unit I visited. The two trustees I interviewed had visibly dirty and frayed masks.
    2. No other inmates were cleaning during my visit.

e. Availability and stock of hygienic and disinfecting supplies for inmates and jail staff
    i. I did not explicitly ask to see stocks of cleaning supplies, hygienic supplies, or PPE. I apologize for this oversight.
    ii. Throughout all three facilities, inmates brought up the inadequacy of PPE. They did not start receiving disposable surgical masks until, per their consistent reports, 4/22/2020. The masks are replaced once every two weeks, which is inadequate since these masks were designed for single use—not sustained use. Some inmates have gone as far trying to wash these masks with soap—which would further damage their integrity. Most of the masks I saw were fraying and/or visibly dirty. The most common date on the masks was 5/6.
    iii. Answers varied widely when I asked inmates if they had enough soap. The soap shown to me were **1 oz.** travel size soaps. They were free of charge.
        1. Division I: Supply was adequate overall.
        2. Division II: Inmates report that they were given 3 soaps every week or **every 2 weeks**. This is remarkably inadequate for regular hand washing and showering, particularly during a pandemic in which people are encouraged to frequently was hands.
        3. Division III: There were no complaints about soap.

f. Availability of communications to inmates about COVID-19 including low-literacy and non-English-speaking people
    i. Posters and written materials: Some materials were posted in most cells and hallways about hygiene and social-distancing. However, the most common materials did not mention COVID-19, and they did not define 6 feet for social distancing. They stated to use tissues (which inmates don't have) and they didn't mention masks. (The only posters that mentioned COVID-19 were in the hallways in Division 3. And these posters were designed for the public with admonitions about staying at home when you're sick). The Wayne County website has some updated materials, but even these are not current. https://www.waynecounty.com/
    ii. Cleaning instructions, schedules, and expectations: I did not see any instructions on how to clean a cell. I did not see any schedule for unit or cell cleanings. Staff reported that the County provides bleach and Simple Green for cleaning. Simple green does not kill COVID-19,

https://simplegreen.com/news-and-media/coronavirus-faq/ Diluted bleach is effective

iii. Inmate interviews:

1. Division I: Some inmates reported that they were told about COVID-19, that it was dangerous, and that they should wear their masks when out of their cells. Others reported they were told nothing. They stated that they received most news via the television.
2. Division II: They stated that they received most information and updates via the television. Most reported they received no information from medical or correctional staff.
3. Division III: Most of these inmates were concerned about what to do when they are released, since they don't want to give COVID-19 to their loved ones. They did not receive this information. Nor did they understand why they were put on 23-hour lockdown because they are sick.

g. Social distancing measures

i. Division I:

1. Cells are generally staggered in occupancy, but there was at least one cell with 2 male inmates. This doesn't allow appropriate distancing.
2. Bars and open grids do not allow for social distancing, since COVID-19 can be transmitted by surface (fomite), where COVID-19 can remain for 2-3, by large droplet, which can be projected at least 6 feet, and by aerosolized particles, which can hang in the air for several hours and can be transmitted through ventilation.
3. In the medical unit, four inmates were on stretchers in one room. All of these men had co-occurring health problems, most were on CPAP or IPAP (breathing machines) due to obstructive sleep apnea. They were positioned in a square, head to foot. They were clearly too close together. While I do not have all their diagnoses, they all likely fit into the category of those at higher risk for severe illness, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html
4. In the women's unit, women were sitting together at the common area tables. One women was doing another woman's hair, neither wearing masks, when we arrived on the floor.

ii. Division II

1. While these are single cells, inmates are allowed to move around in common areas. This doesn't allow appropriate distancing. Unless inmates are on lockdown, no one can walk

in the secured area or the hallway, without being closer than 6 foot to another person.

2. Bars and open grids do not allow for effective social distancing, since COVID-19 can be transmitted by surface (fomite), where COVID-19 can remain for 2-3, by large droplet, which can be projected at least 6 feet, and by aerosolized particles, which can hang in the air for several hours and can be transmitted through ventilation.

iii. Division III

1. Inmates are housed in cells with solid doors—steel and glass. This allows for mitigation of large droplet and aerosolized transmission in ways open bars and grids do not.

h. Ingress/Egress Staff Screenings: The effectiveness of any measure taken to ensure that persons entering the jail, including jail staff, are not carrying the COVID-19 virus

1. Due to the low census, the pandemic, and the day being Saturday, we saw very few people entering and exciting building. All visitors had their temperature taken and were asked three screening questions.
2. Division I; I asked a few officers if they were tested regularly for COVID-19, and they replied that they were tested once. But they get their temperature checked whenever they come into the building. (This is not an effective test, since it has been well-established that asymptomatic people still shed the virus).
3. Division II: I did not ask this question
4. Division III : I did not ask this question

i. Punitive Transfers and Retaliation: There were three recurrent themes that I found very concerning at all three Divisions: one, new inmates in Division one were quarantined for 3 days upon admission; two, inmates were placed on 23-hour lockdown for being testing positive for the virus; three, inmates reported being disincentivized by both medical and correctional staff to seek medical care for anything other than complaints related to coronavirus (while the information that was posted about the virus was inadequate and out of date).

1. Division 1: The coronavirus quarantine unit has men on 23-hour lockdown simply because of the are new to the facility. The quarantine unit hold men for 3 days for observation for development of COVID-19 signs and symptom. I was told by the CO's that this 3-day policy was recommended by Wellpath, the contracted health care provider. I have not seen this policy, but I have also not seen any recommendation for a 3-day observation by the CDC. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-

detention.html The structure of the unit—with open bars--does not allow for social distancing or cohorting inmates in a single unit, so reinfection is possible within a 3-day period.

2. Division 2: The coronavirus quarantine unit has men on 23-hour lockdown simply because of their testing status. The structure of the unit does not allow for social distancing, so reinfection is possible within a 14-day block. Several inmates reported delayed and ignored requests for medical care.
3. Division 3: The coronavirus quarantine unit has men on 23-hour lockdown simply because of their testing status. The structure of the unit does allow for social distancing, but when men are on lock-down, they are unable to speak to each other due to the solid surface doors. This isolation has been shown to increase anxiety, depression, and suicidality among incarceration populations. Inmates reported delayed and ignored requests for medical care.

6. To the extent you were unable to observe, or otherwise obtain information about, any of the above-listed issues, provide an explanation.
    a. I did not inspect an inventory of PPE, cleaning supplies, and hygiene supplies. And that is my fault for not asking. Due to the timeframe of the inspection document being released, I did not have a paper copy of it.
    b. Corporation Counsel seemed to have different interpretations of whom I could and could not interview. I knew I could and should interview inmates. But I also assumed I could speak to officers and medical staff. I was able to speak to all parties at Division I. At Division II, Paul O'Neill took the place of Sue Hammond. He and plaintiff's counsel Allison Kriger argued, in front of us, the appropriateness of me speaking to a nurse in the medical area. While this was off-putting to both the nurse and me, I had the information from the medical staff I needed, and I ended the conversation and apologized to the nurse. I did not attempt to ask questions of the medical staff in Division III.

7. Recommendations

a. Continue reducing the jail population as quickly as possible to reduce sickness and death among inmates, correctional staff, and medical staff. Reducing the size of the population in jails is crucially important to reducing the level of risk both for who both are housed and work within those facilities and for the community at large. Rationale:
    i. From a public health perspective, it is my strong opinion that there is no way short of release to protect the medically vulnerable from grave risk of imminent infection and death.
    ii. Although mitigation and containment strategies are vital, they are merely one piece of the puzzle. The lower the jail or prison population, the more effective these strategies will be. Fewer people in a facility

means best practices will be more possible, fewer community resources will be needed, and other inmates and correctional staff will be safer.

iii. Divisions I and II have no physical barrier on the front cell wall, so even with alternate cell usage, aerosolized virus can infect other inmates in the unit.

iv. In Division II, social distancing is impossible for inmates as well as for staff doing rounds.

b. Develop and implement a schedule for routine testing of all inmates and staff. As long as inmates and staff enter and leave the facilities with their status unknown, the facilities become incubators for the virus. The virus can not only be brought into the facilities; it can be brought back out to stakeholders' homes and communities.

c. Follow CDC guidelines, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

   i. Provide the necessary tools for inmates and staff to mitigate the risk of COVID-19, including, but not limited to
      1. Free soap, on demand, in adequate quantities for hygiene
      2. Use of CDC-recommended cleaning agents on a regular and as-needed basis
      3. Posted cleaning schedules for the trustees and the individual inmates to promote cleaner cells and common area

   ii. Update, post, and distribute up-to-date educational materials in all areas of the jail: Use CDC materials https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. Provide education and guidance to staff, inmates, and other visitors. Review information with all stakeholders on a published, scheduled basis

d. Adjust medical services to meet the demand of this population during the pandemic. Stop disincentivizing inmates from sick call and seeking assistance. Clarify clinic hours for routine care and urgent care, including other infections and trauma. (There are a few photos from this photo that document adverse outcomes from delay in care). Consider expanding telehealth within the walls and among the facilities.

e. Provide adequate PPE. Educate staff, inmates, and visitors regarding proper use of PPE. Staff should role model social distance and mask use. Provide fresh surgical mask no less frequently than weekly. Replace soiled and torn masks as needed.

f. Discontinue double-bunking in Division I. It does not allow for social distancing.

g. Minimize 23-hour lockdown anywhere, but particularly in Division III. These men are essentially being punished for testing positive. They may or may not be ill. The current isolative practice increases anxiety, depression, and suicidality.

h. Develop a back-up plan for cleaning that is not dependent on trustees.

i. Stop housing inmates in Division II as soon as possible. And then stop requiring staff to work there.
    i. The physical conditions are filthy and cannot be adequately cleaned due to pervasive disrepair, irregular surfaces, rust, paint peeling and chipping, mildew, and mold. Individuals in this facility are at an increased risk of, but not limited to, contracting the following: tetanus, contact and airborne infection, worsening of chronic conditions, and exacerbation of respiratory conditions.
    ii. It is impossible for inmates to physically distance when they are out of their cells. Likewise, it is impossible for officers and other staff walking the hallways in the units to maintain 6 feet distance.
    iii. Aerosolized virus cannot be contained in a cell with bars.
    iv. Inmates report and I observed consequences of a level of care and attention far below the other two facilities. It appears that the inmates are not receiving basic medical care or the hygiene supplies.

Fred Rottnek, MD

Fred Rottnek, MD, MAHCM
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Appendix A

Wayne County Question Bank

- How are you?
- What have you been told about COVID-19/Coronavirus?
- What have you been told about physical/social distancing?
- What have you been given to protect yourself? How often are you supplied?
- Have you been told how and why to wear a mask?
- Hygiene supplies (do you have to purchase?)
- Cleaning supplies
- Are people cleaning? How often?
- Do people use their PPE?
- Have you been receiving any needed medical care—including mental health care?
- Have you been able to use Sick Call?
- Are you being locked down differently? More often? How?
- Has staffing patterns changed with officers and/or medical staff?
- Have they changed access to phones and/or other communication?
- What do you want me to know about your experience with COVID-19?

Appendix B

Visit notes

1. **Division I**
    a. Lobby
        i. Limited signage
        ii. Outdated signage
        iii. Signage is from health department
            1. Doesn't mention COVID
            2. Talks about using tissues to cover cough
            3. Doesn't mention masks
    b. Kitchen, spoke with supervisor
        i. "We can't clean like we're supposed to" because they used to have 25-28 trustees, now, only 2.
        ii. "We clean daily"
    c. Medical clinic
        i. When we walked in the two CO's sitting there were sitting side by side, two feet apart, without wearing masks
        ii. When asked about the schedule of providers and if it is currently adequate for inmate needs, the CO's were unsure about the provider schedules. They stated that there is a new doctor being trained.
        iii. Wellpath provides all the medical professionals; the County just has a custodial function. County cleans clinic--it appeared clean, but cluttered.
        iv. Medical apparently recommends a three-day protocol for quarantine/isolation of new inmates. (Unclear where this comes from).
        v. Staff reported that the County provides bleach and Simple Green for cleaning (Simple green does not kill COVID-19, https://simplegreen.com/news-and-media/coronavirus-faq/
        vi. Staff in the medical unit state that they only get temperature checks on a regular basis, not COVID-19 testing
        vii. All inmates were tested on 5/8/20
        viii. Units are provided with mop buckets and cleaning supplies every days. Inmates can use these whenever they ask
        ix. Inmates are written up if they don't clean their cells
        x. In the medical unit, 8 inmates are currently housed in 7 rooms
        xi. One room on the unit had 4 patients in the room. They need regular, daily nursing care, most need CPAP due to sleep apnea. Their beds were not distance 6 or more feet apart. A trustee cleans their shared shower and toilet daily. The recent trustee with this duty was released yesterday.
    d. Housing for inmates with mental health diagnoses
        i. Census is very low on the floor--35 inmates with capacity for 128
        ii. There is no double bunking
        iii. Cell doors/front walls are vertical bars (aerosolized problems)
        iv. The staff admitted they are short on trustees for cleaning

v. Staff stated that they have adequate staffing during the week, but weekends have been challenging--both due to regular staffing shortages and increased shortages due to COVID-19.
vi. We spoke to Dr. McCauley (DNP) who was seeing inmates that day. She has extensive experience working the county and the jails. She feels she has what she needs to take care of inmates. She noted increased anxiety with COVID-19, more isolation, and unease about the future. Dr. McCauley stated she would like increased access to telehealth for the inmates. She finds that an effective way of providing care.

e. 11th floor--Quarantine unit
    i. Nine inmates at present
    ii. Cell doors/front walls are grid-like steel (aerosolized problems)
    iii. This is the unit where inmates are quarantined for 3 days, and, if they display or develop no signs and/or symptoms of COVID-19, they are sent out to another housing unit.
    iv. Inmate interviews
        1. Lemar Stanley (incarcerated for 4 months)
            a. He states he is waiting for a hearing
            b. He reports getting cleaning supplies if he asks for it.
            c. He reports he gets an adequate supply of soap if he asks for it.
            d. He reports no concerns with responsiveness of medical teams or CO's
        2. Damasi Cook (incarcerated for 4 days)
            a. He states he has received no information on COVID-19
            b. He states he recently had surgery on his back (Harper Hospital), but he has not seen a doctor here and his meds weren't continued
            c. He stated cells are not cleaned regularly

f. 8th floor, Women's floor
    i. All the women in Wayne County custody are housed in Division 1
    ii. When we walked in, inmates were using the common space. One women was doing another woman's hair
        1. Inmate interviews
            a. Rhionna Nichols (incarcerated for 6 months)
                i. Overall she states she's doing well
                ii. She reports having adequate cleaning supplies and soap
                iii. She states she was told why she needs to wear mask
                iv. She reported (as did subsequent interviewees) that she gets a new mask once/every two weeks. By then, the mask is dirty and falling apart
            b. Christiana Carey (incarcerated for 6 months)
                i. She's waiting on a court date

ii. She states all the information they get on COVID-19 is from watching the news
iii. She's concerned about the officers bringing in the virus from the outside
iv. She also reports inadequacy of 2 week mask supply
v. She states there is adequate cleaning supplies

g. 10th floor (general population, male)
   i. When we arrived on 10 I saw 2 trustees in the unit. They were standing next to each other with their masks off.
   ii. Inmate interviews
      1. Dave Ellecchia
         a. He was provided no information on COVID-19, on masks or how to use them.
         b. He states they don't get cleaning supplies.
         c. The soap supply is fine.
         d. He also stated the masks were too infrequent
      2. Corey Simms (who didn't wear a mask during the interview through his cell grid)
         a. He stated that he was told nothing about COVID-19
         b. He stated that unit is cleaned only once every few weeks
         c. He stated that 2 nights ago, the CO's took out an inmate on the unit, after telling him in front of everyone that he tested positive
      3. Robert Littner (Incarcerated for 5 months)
         a. He is concerned about the staff coming and in out of the building regularly and bringing the virus into the jail.
         b. He stated that all the inmates got tested on Friday, 5/8/2020.
         c. He stated many of the deputies don't wear masks.
         d. He stated it's difficult to get cleaning supplies.
         e. He reported that when he came in February, he had symptoms consistent with COVID-19, but he could get the staff to take him seriously. So, he faked a faint. He was given a CXR, and a five-day course of antibiotics. Since he didn't get better with that, he was given a course of amoxicillin.
      4. Sean Willis (incarcerated since 2/20)
         a. He states that his court date keeps being pushed 2 weeks at a time
         b. He has sickle cell, and he's had 2 crises since he's been in Division 1, but he hasn't been treated properly.
         c. He feels his health and his legal matters have been delayed "due to Corona"
      5. Robert Moran
         a. On my way out, this inmate stopped me to show me his elbow. He asked me if I thought it was an MRSA infection, because

he can't get anyone to look at it. He states he has put in sick call requests.

2. **Division II**
    a. Signage is old and inaccurate. Similar concerns as above--no mention of COVID-19 or definition of social/physical distancing
    b. Medical unit
        i. Nurse Coleman
            1. I asked her how her work has changed with COVID-19. Her biggest concern is "movement of the inmates." "Why are the inmates still here."
            2. I asked her if she felt they were adequately staffed to manage health care with COVID-19. She stated there should be 3 nurses on each shift and that nurses are working lots of overtime.
            3. I asked if they were able to keep up with chronic care of the inmates and sick calls. She stated "not really, to be honest, due to the shortage.
            4. She offered that 2 of the regular physicians had died from COVID-19.
    c. 6th Floor
        i. Floor plan offers little protection from COVID-19
            1. When inmates are out of the cells (as they were during our visit), they cannot maintain social/physical distancing
            2. Only some of the inmates wore masks at any time
            3. The font and door of each cell is bars
        ii. The building is a state of disrepair, which makes effective cleaning difficult to impossible
            1. Rust on bars and in showers, including the walls and ceiling of showers
            2. Apparently, there is black mold in the shower plumbing
            3. Chipping paint and rust on the most cell doors and walls
            4. The floor is uneven with chips and holes
            5. Vents in inmates are usually at least partially blocked by dirt and airborne dust
        iii. Inmates report that they receive 3 small travel-size motel soaps each week.
        iv. Inmates report that they often request cleaning materials, but they are told that they don't have any.
        v. Inmate interviews
            1. Deangelo Butts (Incarcerated for 6 months)
                a. They learn about COVID-19 from the news. The signs up on social distancing aren't possible in their set up.
                b. He states that he's concerned that he has bronchitis, but he has no meds and can't get an appointment.
            2. Barius Robison (incarcerated 13 months, to be released Monday)
                a. He states they first received masks on 4/22
                b. Social distancing is impossible

    c. He is worried about sheriffs bringing virus into the facilities, and they are inconsistent with wearing masks
3. Christopher Moore (incarcerated 10 months, waiting on trial)
    a. He states food quality has deteriorated further.
    b. He is awaiting test results from 5/8
    c. He demonstrated that there is poor water pressure with timed water faucet
    d. He commented on the inadequacy of soap and showed me the ~ 1 oz. travel size bar.
4. Omar Taylor (incarcerated 8 months)
    a. He demonstrated the apparent black mold/contaminant that is part of the plumbing by pressing the communal shower button and showing me the black substance that accumulated on his thumb as a result
    b. He has developed a conjunctivitis to his right eye. It took him over a week to be seen by the nurse. He was given a bottle of normal saline for treatment. He still has signs of a conjunctivitis.
5. Murray Stuart (incarcerated for one year)
    a. He commented on what he thinks is bird excrement on the bars and heaters throughout the units
6. Darnell Moore
    a. He commented on roaches and bird excrement he has commonly seen in the facility
    b. He is still waiting on his test results from 5/8
    c. He stated the they have just been provided cleaning supplies on a daily basis in recent weeks. Prior to that, they only had supplies 3x/week.
    d. He also commented on the inadequacy of soap supplied.
7. James McCoy
    a. He states he had to submitted multiple sick calls for a swollen right 5th finger. After it burst with infection, he was seen and treated (photo taken)
8. Marcus Lynn (incarcerated 11 months)
    a. He complained of severe neck pain for 6-7 months. He submitted several sick calls. He was never seen, but the pain resolved on its own.
    b. He states he has only seen spraying in the unit down during his incarceration.
    c. He states he has asked for cleaning supplies, but he has been told there are none.
    d. He commented on the inadequacy of soap

9. Anthony Childs
    a. He states he was written up and locked up for sending out a video reporting on the conditions in Division #2
10. Jason Bell
    a. He states he was told “Unless you’re dying, you won’t go to clinic”
11. Jason Childs
    a. He states the hot water doesn’t work
    b. He stated that medical doesn’t respond to medical complaints and sick call
    c. He pointed out to me the clogged vents in the cells and the rust on the ceiling of the communal shower
12. Sylvester Cornelius (he acted as a facilitator of a discussion on 613) Inmates on that unit, in that discussion, shared concerns
    a. Masks were first distributed on 4/22, and the one mask allocation every 2 weeks is inadequate
    b. They are still waiting on their test results—why did they move some inmates and not others if they don’t have all the test results?
    c. Medical hasn’t answered their sick calls
    d. Two days ago, a COVID+ inmate was moved out. “We need to be retested.”
13. James Matthews (incarcerated for 2 years)
    a. He reports having a valve replacement, hypertension, and asthma
    b. He states he brought his medication in with him, but he has not received them since he has been incarcerated
14. David Grier (incarcerated for 10 months)
    a. He states he completed his bond reduction papers 3 weeks ago, but he has not heard back from anyone
15. Michael Beeve (incarcerated for 10 months)
    a. He states he has hypertension, diabetes, and psychological problems. “Since the pandemic, everything changed.” He states that all his medications were changed without any visit or evaluation by medical.
16. Delano Marquez (incarcerated 2 months)
    a. He states he’s on the wrong chronic medications, even though he’s told medical that they can find his meds at CVS
    b. He has a dental abscess on a left upper molar and he has only received Tylenol
    c. He has not seen a doctor, even though he has put in multiple sick calls

d. 4th floor
    i. In these units, we were told by the sheriffs that they may be COVID-19 positive, but they weren't certain. However, we had to gown up in full PPE, including protective suit, face mask, N95, and gloves
    ii. The inmates on these pods all told similar stories that they were tested on 5/8 and then moved down to the 4th floor the week of 4/11. Few had masks on when I spoke to them. When I asked those who were not wearing masks why, they replied that they were not given mask. They stated that their care consisted of Tylenol and Gatorade.
    iii. Inmate interviews
        1. Aaron Davis (incarcerated for 9 months)
            a. He reported loss of taste and smell
            b. He reported he was told nothing when he was moved to the unit other than he tested positive
        2. Joshua Brown (incarcerated for 5 months)
            a. He has chronic life-long asthma
            b. He was given a rescue inhaler, but no control inhaler, although he's been on that in the best
            c. He has not been able to receive a nebulized breathing treatment, even though he has asked for one.
        3. Craig Gullege (incarcerated for 4 months)
            a. He was really sick on admission—sick enough to be moved to the infirmary, but he was not tested
            b. He has had chest pain on and off for 3 days this week—sharp, centralized chest pain, and he has hypertension; he was only given Tylenol
        4. Darrel Smith
            a. He states he has had no PPE since mid-March. He states that there are many times when they have no cleaning supplies
        5. Damon Bailey (incarcerated 10 months)
            a. He states that he's had chills, HA and fever for a week or two
        6. Steve Williams
            a. He states he has had "all the symptoms" for 2 weeks
            b. He asked one of the CO's "Big Girl" when they were going to get tested, and she said, "We'll take care of that later."
        7. Cornelius Barnes
            a. He states he was concerned when he had "all the symptoms, because he had a history of a gunshot wound to the chest and lung involvement. He noted the lack of masks.
        8. Kyle Dyas
            a. Reports feeling light-headed and dizzy.

3. **Division III**
    a. We toured the Intake area, where social distancing was maintained.
    b. We toured the kitchen, where social distancing was maintained. But masks were worn incorrectly by those working.
    c. We toured the laundry, which was not active since it was a Saturday. It was a large room with plenty of room for distancing.
    d. We visited the medical clinical, which was not very active, since it was a Saturday. Three medical staff were present. I did not ask them questions.
    e. There were signs in the hallway and in the units we visited. They were COVID-19 specific; however, they had the old signs and symptoms—not the newer expanded signs and symptoms list by the CDC. They were also oriented to the general public, with workplace and school concerns.
    f. The cells in the units we visited were typical of modern jail design with glass windows and steel doors on each cell.
    g. Inmates in the first unit I visited were part of a domestic violence education program. While we were told by the staff that all programs were suspended, inmates told me that the domestic violence program had not been. They said that other inmates had been released since their programs were suspended. They wondered why their program had been continued. The instructor looked unwell, was obese, and didn't wear his PPE consistently. Inmates were afraid he was bringing the virus into the facility.
    h. While we were visiting the first unit, trustees were cleaning in the common area.
    i. Many inmates stated that they were unclear who was moved back and forth between the two open units and why.
    j. Facilities were newer than the other facilities. However, tiles were missing in many showers, and the fixtures and tiles had rust and mildew present.
    k. The second unit we toured housed inmates who tested positive for COVID-19. All of them reported being on 23-hour lockdown due to the fact that they have COVID-19. Only one inmate is allowed out at a time to take care of their business. This isolation was reported by most of the mean that this heightened the anxiety in general and their fear of increasing illness in particular.
    l. Inmates were tested on 5/9. Some inmates were moved over to the COVID-19 unit as a result. Most of the inmates had not been informed of their testing results yet.
    m. Inmate interviews (First unit)
        i. Marcus Russell (First day incarcerated) He was sitting in the common area and was sweating profusely. He stated he felt fine otherwise, but there was no ventilation in the room—that's why he was sweating.
            1. He stated he has asthma, but he hasn't talked to a nurse yet for his inhaler.
        ii. Derrick Houston (incarcerated for 6 months)
            1. He was wearing his mask incorrectly
            2. He stated things were OK, except he was frustrated by all the hearing delays.
            3. He noted that cleaning seems to be happening.

iii. Ray Culbertson, trustee (incarcerated for 4 months)
    1. He was not wearing his mask correctly
    2. He stated he asked to be part of the cleaning crew because he was really anxious about catching the virus. This way he could make sure someone was doing it right—not everyone was.
    3. He has diabetes, asthma, and hypertension—he said he was getting his medications.
    4. He noted the masks were also first distributed on 4/22, and they don't last the whole 2 weeks.
    5. He is observing Ramadan, but he is upset that they put his tray on the floor at night—"why is that necessary?"
    6. He stated that he wants to know how hearings are determined? He hasn't had a hearing yet.

iv. Mika Simpson, trustee (incarcerated for 6 months)
    1. He was upset that they move people back and forth between pods before people know their test results. He states the moves didn't make sense
    2. He states he has schizophrenia. He had stopped his meds because he couldn't participate in the domestic violence program because he couldn't concentrate on the meds. He would like to restart them now. He stated concerns about the health of the instruction.
    3. He said many men try washing their masks with soap because they get so dirty over 2 weeks.
    4. He states that there have been periods when they were out of soap.

n. Inmate Interviews (Second unit—COVID+ unit)
    i. Ariel Sunday (incarcerated 3+ months)
        1. He was a pod worker since the beginning of March.
        2. He soon felt sick—problems with vision and moving. He asked to see medical and was told, "They don't want to see anyone." He told me that at the time, "They were working under the assumption that if you have no temperature, you don't have COVID." Eventually, they sent him to medical. He had no temp, so they sent him back to his unit.
        3. He noticed after this that many people were getting sick, and the first seven or eight were pod workers.
        4. He was transferred to Division #1 at the end of March/beginning of April because he got into a fight. He states he was transferred on the same day that eight officers tested positive. He was there for over 5 weeks. On 5/5, he was called to the clinic, because he has a history of asthma and an auto-immune disorder. He had a fever of 107, and he was transferred to this unit on Division #3
        5. He just received his own inhaler last week. He reports that he refused the albuterol offered before because the inmates have to use the same inhaler.
        6. He reports having no contact with his attorney since 2/2020.

ii. Darron Thomas (incarcerated at #3 for 37 days after 6 months in Division #1)
    1. He's frustrated that the rules for 23-hour lockdown don't make sense. He's felt anxious and suicidal.
    2. He's not received any response from medical for his asthma.
    3. When he was in Division #1, faked passing once in order to get medical attention
iii. Deandre Paul (incarcerated since 1/31/2020)
    1. Felt ill in the end of February and again in the end of April, but his first test was 5/9.
    2. He has asthma and sleep apnea and again mentioned the common-use inhaler.
    3. "Why won't they just let us go?"

DECLARATION OF DR. MARC STERN, MD MPH

On this 14th day of April, 2020, I hereby declare:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. On a regular basis, I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections. In terms of educational background, I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University in 1992. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

2. My prior experience includes working with the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails. Through 2013, I taught the National Commission on Correctional Health Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train

jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course. I currently also serve as the COVID-19 expert resource to the National Sheriffs Association and the Washington Association of Sheriffs and Police Chiefs.

3. In the past four years alone, I have been qualified as an expert in several jurisdictions on correctional health care systems and conditions of confinement. Attached as Exhibit A is a copy of my curriculum vitae.

4. I am not receiving payment in exchange for providing this affidavit to counsel for the Plaintiffs regarding appropriate correctional healthcare measures during the COVID-19 pandemic. In light of the emergency conditions occurring in jails and prisons across the country, I am providing my services *pro bono.*

5. I am familiar with the virus from a clinical perspective, including its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through correctional facilities.

6. In the context of a pandemic like the one we currently face, public health and public safety interests are closely intertwined. When and if correctional staffing challenges arise due to the need for staff to quarantine, seek treatment, or care for dependents, managing internal safety in carceral settings becomes

even more challenging. Understaffing in the correctional setting is dangerous for staff as well as incarcerated people, and the stress and fear of the current crisis only serve to increase those risks.

7. Jails and prisons are congregate environments, i.e. places where people live, eat, shower, and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch, as does COVID-19 – are more likely to spread. The spread of COVID-19 in similar environments such as nursing homes and cruise ships, and now correctional facilities themselves, has already been demonstrated.

8. The CDC and other public health authorities recommend a number of preventive steps to prevent or decrease the spread of COVID-19. It can be difficult if not impossible to execute all these recommendations or execute them effectively in jails and prisons, placing people at risk.

9. Although it is important for jails to comply with the CDC recommendations, it is equally important to understand that compliance with these standards alone is not enough to create a carceral setting that fully protects the health and safety of the people detained there. First of all, although the CDC guidelines are based on science, as a federal institution, CDC would avoid issuing recommendations, such as downsizing, that can be seen as imposing requirements on local governments around the country, even when the science would support

such recommendations. Second, and relatedly, the CDC guidelines incorporate a "harm reduction" approach, a common practice in public health guidance. The harm reduction approach recognizes that though there is an appropriate and safe way to address a public health problem, people do not always do things in that way, and so provides guidance on how to reduce risk of harm even when not following the appropriate practices. For example, the CDC guidance, like public health guidance everywhere, states that social distancing should permit six feet or more of social distancing between sleeping quarters, but also states that such distancing should be provided "if space allows." This does **not** mean that it is safe to have less than six feet of social distance in a jail, and in fact a carceral setting that does not allow for such social distancing is not a safe one and is likely to facilitate the spread of COVID-19.

10. For this reason, it is also important to reduce the number of persons incarcerated. I recognize that in most institutions, this number cannot be reduced to zero. However, the lower the number, the lower the risk. In other words, reducing the population to, say, a number that allows single occupancy in all rooms is better than maintaining a higher population number, but will still not achieve the level of risk that would exist if the population were released.

11. Downsizing jail populations serves two critical public health aims: (1) targeting residents who are at elevated risk of suffering from severe symptoms

of COVID-19 ("medically at-risk"); and (2) allowing those who remain incarcerated to maintain social distancing and avoid other risks associated with forced communal living. Because medically at-risk populations are at the highest risk of severe complications from COVID-19, and because when they develop severe complications they will be transported to community hospitals—thereby using scarce community resources (ER beds, general hospital beds, ICU beds)—avoiding disease in this population is a critical contribution to public health overall. Because the staff who work at the jail share risk with the communal residents, reducing spread of infection in the jail significantly reduces the chances of a staff member infecting his or her family or community.

12. Downsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to "flatten the curve" overall—both within the jail setting and without.

13. Thus, taking immediate and concerted efforts to implement preventive steps, as well as reducing the population to the lowest number possible prioritizing those who are elderly or have underlying medical conditions defined by the CDC, will increase public safety via reducing public health risk.

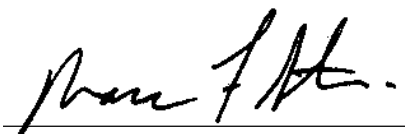
14. For the first time in history, large scale decisions about incarceration need to be made on the basis of public safety, not only considering criminal justice-related factors, but also public health-related factors.

15. I have reviewed the declarations of Jamaal Cameron and Richard Briggs. If accurate, they highlight a number of conditions or practices that are inconsistent with current public health recommendations: crowded conditions which do not allow safe distancing; unsafe practices for isolating residents with suspected COVID-19; inadequate disinfection of frequently touched common surfaces, inadequate provision of supplies for disinfecting surfaces; inadequate provision of hand soap, and inadequate access to episodic care (barriers to requesting care and insufficient evaluation when care is accessed).

16. Thoughtful downsizing that takes into account public safety, based not only criminal justice-related factors, but also public health-related factors, should be implemented in tandem with aggressive prevention measures that are based on national recommendations, modified, as necessary by public health and medical experts to adapt to the unique combination of physical structure and layout, operations, policies, logistics, inmate characteristics, and staffing factors of the jail.

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

Executed on April 14, 2020.



Marc Stern, MD MPH

EXHIBIT A
CV of Dr. Marc Stern

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

April, 2020

marcstern@live.com
+1 (360) 701–6520

SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

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

REVIEWER/EDITOR

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

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

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

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS/ABSTRACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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EXPERT TESTIMONY

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

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

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

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

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

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

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

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I am being paid $1,000 for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

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

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

[1] *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

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[2] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

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

[4] This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

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

[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice*: *New Jersey*, *Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.

26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

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[9] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.

38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.

39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.

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

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

March 15, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

EXHIBIT A

CURRICULUM VITAE

Date of Revision:	November 20, 2019
Name:	Jaimie Meyer, MD, MS, FACP
School:	Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
MD, University of Connecticut School of Medicine 2005
MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008	Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
2008 - 2011	Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
2008 - 2012	Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
2010 - 2012	Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
2012 - 2014	Instructor, AIDS, Yale School of Medicine, New Haven, CT
2014 - present	Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
2015 - 2018	Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
AB of Internal Medicine, Infectious Disease, 10-2010
AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018	NIH Center for Scientific Review, Selected as Early Career Reviewer
2017	Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
2016	American College of Physicians, Fellow
2016	NIH Health Disparities, Loan Repayment Award Competitive Renewal
2016	AAMC, Early Career Women Faculty Professional Development Seminar
2014	NIH Health Disparities, Loan Repayment Program Award
2014	NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
2014	International Women's/Children's Health & Gender Working Group, Travel Award
2014	Patterson Trust, Awards Program in Clinical Research
2013	Connecticut Infectious Disease Society, Thornton Award for Clinical Research
2011	Bristol Myers-Squibb, Virology Fellows Award

2006	NY Columbia Presbyterian, John N. Loeb Intern Award
2005	American Medical Women's Association, Medical Student Citation
2005	Connecticut State Medical Society, Medical Student Award
2000	Dartmouth College, Hannah Croasdale Senior Award
2000	Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University

2014	Women's Faculty Forum, Public Voices Thought Leadership Program Fellow

Grants/Clinical Trials History:

Current Grants

Agency:	Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#:	2019-20 Pilot Project Awards
Title:	Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.:	Tiara Willie
Role:	Principal Investigator
Percent effort:	2%
Direct costs per year:	$29,993.00
Total costs for project period:	$29,993.00
Project period:	7/11/2019 - 7/10/2020

Agency:	SAMHSA
I.D.#:	H79 TI080561
Title:	CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role:	Principal Investigator
Percent effort:	20%
Direct costs per year:	$389,054.00
Total costs for project period:	$1,933,368.00
Project period:	11/30/2018 - 11/29/2023

Agency:	Gilead Sciences, Inc.
I.D.#:	Investigator Sponsored Award, CO-US-276-D136
Title:	Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role:	Principal Investigator
Percent effort:	8%
Direct costs per year:	$81,151.00
Total costs for project	

period:	$306,199.00
Project period:	6/19/2018 - 1/31/2020

Agency:	NIDA
I.D.#:	R21 DA042702
Title:	Prisons, Drug Injection and the HIV Risk Environment
Role:	Principal Investigator
Percent effort:	22%
Direct costs per year:	$129,673.00
Total costs for project period:	$358,276.00
Project period:	8/1/2017 - 7/31/2020

Agency:	Doris Duke Charitable Foundation
I.D.#:	Clinical Scientist Development Award
Title:	Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Role:	Principal Investigator
Percent effort:	27%
Direct costs per year:	$149,959.00
Total costs for project period:	$493,965.00
Project period:	7/1/2017 - 6/30/2020

Past Grants

Agency:	NIDA
I.D.#:	K23 DA033858
Title:	Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
Role:	Principal Investigator
Percent effort:	75%
Direct costs per year:	$149,509.00
Total costs for project period:	$821,147.00
Project period:	7/1/2012 - 11/30/2017

Agency:	Robert Leet & Clara Guthrie Patterson Trust
I.D.#:	R12225, Award in Clinical Research
Title:	Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$75,000.00

Total costs for project period:	$75,000.00
Project period:	1/31/2014 - 10/31/2015

Agency:	Bristol-Myers Squibb
I.D.#:	HIV Virology Fellowship Award
Title:	Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$34,390.00
Total costs for project period:	$34,390.00
Project period:	12/1/2011 - 11/30/2012

Pending Grants

Agency:	NIMH
I.D.#:	R01 MH121991
Title:	Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
P.I.:	Sullivan, Tami
Role:	Principal Investigator
Percent effort:	30%
Direct costs per year:	$499,755.00
Total costs for project period:	$4,148,823.00
Project period:	1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:

International/National

2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"

2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"

2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"

2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"

2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"

2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"

2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"

2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"

2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"

2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:

International/National

2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"

2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"

2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"

2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"

2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"

2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""

2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"

2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"

2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"

2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"

2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"

2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"

2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"

2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"

2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"

2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"

2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"

2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"

2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"

2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"

2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"

2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"

2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"

2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"

2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers

2019 - present Reviewer, Yale DCFAR Pilot Projects

2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)

2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

2019 - present Associate Editor, Journal of the International Association of Providers of AIDS Care (JIAPAC), Section Editor: Sex and Gender Issues

Reviewer

2019 - present Reviewer, JAIDS

2012 - present Reviewer, Addiction Sci and Clin Pract

2012 - present Reviewer, Addictive Behav Reports

2012 - present Reviewer, AIDS Care

2012 - present Reviewer, Social Science and Medicine

2012 - present Reviewer, SpringerPlus

2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy

2012 - present Reviewer, Women's Health Issues

2012 - present Reviewer, Yale Journal of Biology and Medicine

2012 - present Reviewer, AIMS Public Health

2012 - present Reviewer, American Journal on Addictions

2012 - present Reviewer, American Journal of Epidemiology

2012 - present Reviewer, American Journal of Public Health

2012 - present Reviewer, Annals Internal Medicine

2012 - present Reviewer, BMC Emergency Medicine

2012 - present Reviewer, BMC Infectious Diseases

2012 - present Reviewer, BMC Public Health

2012 - present Reviewer, BMC Women's Health

2012 - present Reviewer, Clinical Infectious Diseases
2012 - present Reviewer, Critical Public Health
2012 - present Reviewer, Drug and Alcohol Dependence
2012 - present Reviewer, Drug and Alcohol Review
2012 - present Reviewer, Epidemiologic Reviews
2012 - present Reviewer, Eurosurveillance
2012 - present Reviewer, Health and Justice (Springer Open)
2012 - present Reviewer, International Journal of Drug Policy
2012 - present Reviewer, International Journal of Prisoner Health
2012 - present Reviewer, International Journal of STDs and AIDS
2012 - present Reviewer, International Journal of Women's Health
2012 - present Reviewer, JAMA Internal Medicine
2012 - present Reviewer, Journal of Family Violence
2012 - present Reviewer, Journal of General Internal Medicine
2012 - present Reviewer, Journal of Immigrant and Minority Health
2012 - present Reviewer, Journal of International AIDS Society
2012 - present Reviewer, Journal of Psychoactive Drugs
2012 - present Reviewer, Journal of Urban Health
2012 - present Reviewer, Journal of Women's Health
2012 - present Reviewer, Open Forum Infectious Diseases
2012 - present Reviewer, PLoS ONE
2012 - present Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)
2016 - present Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians
2016 - present Fellow, American College of Physicians
2013 - 2016 Member, American College of Physicians

American Medical Association
2005 - present Member, American Medical Association

American Medical Women's Association
2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine
2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine

2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School

2013 - present Mentor, Women in Medicine at Yale Mentoring Program

2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS

2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

1. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Emergency department use by released prisoners with HIV: an observational longitudinal study. PloS One 2012, 7:e42416.
2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. Journal Of Immigrant And Minority Health / Center For Minority Public Health 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. AIDS And Behavior 2013, 17 Suppl 2:S118-27.

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7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. International Journal Of Prisoner Health 2013, 9:124-41.
8. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Frequent emergency department use among released prisoners with human immunodeficiency virus: characterization including a novel multimorbidity index. Academic Emergency Medicine : Official Journal Of The Society For Academic Emergency Medicine 2013, 20:79-88.
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10. **Meyer JP**, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender disparities in HIV treatment outcomes following release from jail: results from a multicenter study. American Journal Of Public Health 2014, 104:434-41.
11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. JAMA Internal Medicine 2014, 174:721-9.
12. **Meyer JP**, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. American Journal Of Public Health 2015, 105:1901-10.
13. Boyd AT, Song DL, **Meyer JP**, Altice FL. Emergency department use among HIV-infected released jail detainees. Journal Of Urban Health : Bulletin Of The New York Academy Of Medicine 2015, 92:108-35.
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15. Peasant C, Sullivan TP, Weiss NH, Martinez I, **Meyer JP**. Beyond the syndemic: condom negotiation and use among women experiencing partner violence. AIDS Care 2017, 29:516-523.
16. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, **Meyer JP**, El-Bassel N, Mayer KH, Kamarulzaman A, Altice FL. Prevalence of Human Immunodeficiency Virus and Sexually Transmitted Infections Among Cisgender and Transgender Women Sex Workers in Greater Kuala Lumpur, Malaysia: Results From a Respondent-Driven Sampling Study. Sexually Transmitted Diseases 2017, 44:663-670.
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18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. AIDS Care 2018, 30:1282-1289.
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29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. Drug And Alcohol Dependence 2010, 112:178-93.
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31. **Meyer JP**, Chen NE, Springer SA. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. AIDS Research And Treatment 2011, 2011:680617.
32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. Infectious Disease Reports 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. Sexually Transmitted Infections 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award). Oxford University Press 2015. ISBN 9780199360574.
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Peer-Reviewed Educational Materials

43. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014
44. United Nations Office on Drugs and Crime. Vienna, Austria

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. Journal Of General Internal Medicine 2014, 29:1164.
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Case Reports, Technical Notes, Letters

48. **Paul J**. Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
49. How J, Azar MM, **Meyer JP**. Are Nectarines to Blame? A Case Report and Literature Review of Spontaneous Bacterial Peritonitis Due to Listeria monocytogenes. Connecticut Medicine 2015, 79:31-6.
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Scholarship In Press

54. Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J**. Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health

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

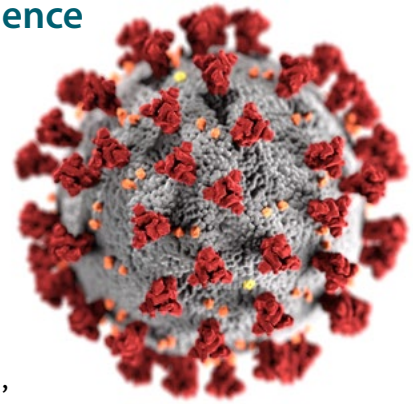
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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

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

In this guidance

Who is the intended audience for this guidance?



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

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

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

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

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

√ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**

- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
- Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
- Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.

√ **Coordinate with local law enforcement and court officials.**

- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
- Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

√ **Post signage throughout the facility communicating the following:**

- **For all:** symptoms of COVID-19 and hand hygiene instructions
- **For incarcerated/detained persons:** report symptoms to staff
- **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
- Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

√ **Review the sick leave policies of each employer that operates in the facility.**

- Review policies to ensure that they actively encourage staff to stay home when sick.
- If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- Determine which officials will have the authority to send symptomatic staff home.

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

Operations & Supplies

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

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

√ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**

- See CDC guidance optimizing PPE supplies.

√ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.

√ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)

- Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

√ **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**

√ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

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

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

Operations

√ **Stay in communication with partners about your facility's current situation.**

- State, local, territorial, and/or tribal health departments
- Other correctional facilities

√ **Communicate with the public about any changes to facility operations, including visitation programs.**

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

Cleaning and Disinfecting Practices

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

Hygiene

√ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**

√ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials **are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

- **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
- **Practice good** hand hygiene**:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
- **Avoid sharing eating utensils, dishes, and cups.**
- **Avoid non-essential physical contact.**

√ **Provide incarcerated/detained persons and staff no-cost access to:**

- **Soap—**Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
- **Running water, and hand drying machines or disposable paper towels for hand washing**
- **Tissues** and no-touch trash receptacles for disposal

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.

√ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

√ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).

- **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
  - Require the individual to wear a face mask.
  - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
  - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
  - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

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

- **Common areas:**
  - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
- **Recreation:**
  - Choose recreation spaces where individuals can spread out
  - Stagger time in recreation spaces
  - Restrict recreation space usage to a single housing unit per space (where feasible)
- **Meals:**
  - Stagger meals
  - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
  - Provide meals inside housing units or cells
- **Group activities:**
  - Limit the size of group activities
  - Increase space between individuals during group activities
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
  - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
- **Housing:**
  - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
  - Arrange bunks so that individuals sleep head to foot to increase the distance between them
  - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
- **Medical:**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
  - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

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

Prevention Practices for Staff

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

√ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**

√ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

√ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**

√ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.

- Staff performing temperature checks should wear recommended PPE.
- Exclude visitors and volunteers who do not clear the screening process or who decline screening.

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**

√ **Provide visitors and volunteers with information to prepare them for screening.**

- Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
- If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
- Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.

√ **Promote non-contact visits:**

- Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
- Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
- Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.

√ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**

- If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
- Inform potential visitors of changes to, or suspension of, visitation programs.
- Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
- If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

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

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

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

Management

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

Operations

√ **Implement alternate work arrangements deemed feasible in the** Operational Preparedness **section.**

√ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**

- If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.

√ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.

√ **When possible, arrange lawful alternatives to in-person court appearances.**

√ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**

- Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
  - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
  - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
  - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

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

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

Hygiene

√ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)

√ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

√ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)

√ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

√ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**

√ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**

- Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
- Serve meals to cases inside the medical isolation space.
- Exclude the individual from all group activities.
- Assign the isolated individual a dedicated bathroom when possible.

√ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.

√ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.

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

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

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

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

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

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

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

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

√ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:

- o **Cover** their mouth and nose with a tissue when they cough or sneeze
- o **Dispose** of used tissues immediately in the lined trash receptacle
- o **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

√ **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**

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

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

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

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

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

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

√ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**

- o If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

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

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

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

√ **Electronics cleaning and disinfection**

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

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

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

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

√ Laundry from a COVID-19 cases **can be washed with other individuals' laundry.**

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

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

√ **Consult** cleaning recommendations above **to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

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

√ **Incarcerated/detained persons who are close contacts of a** confirmed or suspected COVID-19 case **(whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**

- If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.

√ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**

- Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
- Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

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

√ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**

- Provide medical evaluation and care inside or near the quarantine space when possible.
- Serve meals inside the quarantine space.
- Exclude the quarantined individual from all group activities.
- Assign the quarantined individual a dedicated bathroom when possible.

√ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.

- If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation immediately.
- If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
- Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

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

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

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

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

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

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

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

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

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

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

√ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.

√ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**

- If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
- If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

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

√ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**

- Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
- Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

√ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See Screening section for a procedure to safely perform a temperature check.

√ **Consider additional options to intensify** social distancing within the facility.

Management Strategies for Staff

√ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**

- Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.

√ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**

- See above for definition of a close contact.
- Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

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

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).

√ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).

√ **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

√ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**

- If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
- The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.

√ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**

√ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.

√ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**

√ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**

√ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

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

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

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

√ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**

√ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (**see Table 1). **Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**

√ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**

√ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**

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

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

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

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

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

- **Guidance in the event of a shortage of N95 respirators**
  - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
- **Guidance in the event of a shortage of face masks**
- **Guidance in the event of a shortage of eye protection**
- **Guidance in the event of a shortage of gowns/coveralls**

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

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

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

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

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

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

- √ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- √ **The following is a protocol to safely check an individual's temperature:**
  - Perform hand hygiene
  - Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - Check individual's temperature
  - **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - Remove and discard PPE
  - Perform hand hygiene

DECLARATION OF DR. ADAM LAURING

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

I. Background and Qualification

1. My name is Adam Lauring, M.D., Ph.D.

2. I am a board-certified medical doctor in Infectious Diseases

3. I have been a physician for more than 18 years, and I have worked in Infectious Diseases for 14 years and in Virology for 13 years.

4. Since 2012, I have been on the faculty at the University of Michigan where my research has focused on population genetics and the evolution and transmission of RNA viruses. I am currently an Associate Professor. In response to the COVID-19 pandemic, I am leading two studies to help determine how the novel coronavirus's behavior changes from one person to the next and how it transmits.

5. My bio, attached as Exhibit A, includes a brief description of my education and relevant experience

6. My Curriculum Vitae, attached as Exhibit B, includes a full list of my honors, experience, and publications.

7. I am donating my time reviewing materials and preparing this Declaration. Any live testimony I provide will also be *pro bono*.

II. Heightened Risk of Epidemics in Jails and Prisons

8. As I will discuss below, the risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of multiple risks of transmission and exposure to individuals who become infected.

9. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails, however, are closely connected to communities. Staff, visitors, contractors, and vendors pass between communities and these facilities and, if infected, these individuals can carry with them and transmit infectious diseases. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities, posing the same risk. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

10. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people share dining halls, bathrooms, showers, telephones, and other common areas, the opportunities for transmission are greater. Where infectious diseases are transmitted from person to person by droplets, and no vaccine exists, the best initial strategy is to practice social distancing – maintaining a physical distance of at least six feet from any other person. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community.

11. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting, therefore, dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases, and significantly increases the likelihood of the spread of infection. For example, in mid-March, the jail at Rikers Island in New York City had not had a single confirmed COVID-19 case. By March 30, 167 inmates, 114 correction staff, and 20 health workers at Rikers tested positive for COVID-19, two correction staff members have died, and multiple inmates have been hospitalized.[1] As of April 8, Rikers had a rate of infection that is far higher than the infection rates of the most infected regions of the world. More than 700 people have tested positive for

[1] Jan Ransom, *We're Left for Dead: Fears of Virus Catastrophe at Rikers Jail*, N.Y. Times, Mar. 30, 2020.

COVID-19, including more than 400 staff.[2] The Chief Medical Officer of Rikers has described the situation as a "public health disaster unfolding before our eyes." In his view, following CDC guidelines has not been enough to stem the crisis: "infections in our jails are growing quickly despite these efforts."[3] Like the explosive growth at Rikers, the Cook County Jail went from two confirmed COVID-19 cases on March 23 to more than 350 confirmed cases, 238 inmates and 115 staff members, two weeks later.[4] As of April 13, the number of confirmed cases totaled 500, of which two-thirds are inmates.[5]

12. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other jail or prison inmates, staff, and visitors.

13. Reduced prevention opportunities: During an infectious disease outbreak for which no vaccine is available, the single most effective way to prevent or reduce the risk of infection is to practice social distancing. If social distancing cannot meaningfully be practiced, then it is impossible

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

[3] Ross MacDonald (@RossMacDonaldMD), Twitter (Mar. 30, 2020, 8:03 PM), https://twitter.com/rossmacdonaldmd/status/1244822686280437765?s=12 ("I can assure you we were following the CDC guidelines before they were issued. We could have written them ourselves. . . [I]infections in our jails are growing despite these efforts.").

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

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

to prevent the spread of infection. Nevertheless, people can take measures to reduce their risk of infection by washing hands. Jails and prisons often do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers. When handwashing is unavailable, then the risk of infection and rate of infection spread is much greater. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, telephones, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

14. Additional reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and their caregivers must use in every interaction personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk to everyone in the facility of a widespread outbreak.

15. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[6] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

16. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne

[6] Active case finding for communicable diseases in prison, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms, if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes containing the illness and caring for those who have become infected nearly impossible.

17. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, medications, and specialized equipment, such as ventilators.

18. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During a pandemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves. The patient volume at Detroit's Sinai-Grace Hospital is so overwhelming that patients are lining the hallways, and patient care is suffering from staff, supplies, and equipment shortages.[7] In some cases, patients have died waiting for medical attention.[8] To help ease the collective burden on Southeastern Michigan hospitals, the state is constructing field hospitals.[9]

19. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems

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

[8] *Id*.

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

inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines may be limited. Locally, for example, two Wayne County Jail physicians, including the Jail's medical director, have died from COVID-19.[10]

20. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public. Furthermore, rapid spread of infectious diseases among the inmates can often worsen the epidemic outside of the incarcerated population because staff are more likely to be infected and spread the disease to their families and the wider population.

21. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[11] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[12] Even facilities on "quarantine" continued to accept new cases" of influenza, a viral infection for which there was an effective and available vaccine and

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

[11] *Influenza Outbreaks at Two Correctional Facilities—Maine, March 2011,* Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

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

antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[13]

22. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but recent data from China has demonstrated that almost 13% of transmission occurs from asymptomatic individuals before they start to show symptoms, and it is possible that transmission can occur for weeks after their symptoms resolve.[14] In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. A recent study out of Singapore found 10% of new infections could be caused by asymptomatic patients.[15] Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be available for over a year to the general public. Antiviral medications are currently in testing but not yet FDA-approved.

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[13] This whole section draws from Broks J. Global Epidemiology and Prevention of COVID19, COVID-10 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); Coronavirus (COVID-19), Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, COVID-19 (Coronavirus): What You Need to Know in Corrections, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

[14] Du Z, Xu X, Wu Y, Wang L, Cowling BJ, Ancel Meyers L. Serial interval of COVID-19 mong publicly reported confirmed cases. Emerg Infect Dis. 2020 Jun (accessed April 30, 2020). https://doi.org/10.3201/eid2606.200357.

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

People in prison and jail will likely have even less access to these novel health strategies as they become available.

23. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection, but emerging data from China suggests serious illness—including death—occurs in up to 16% of cases.[16] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[17] 74% of cases requiring hospitalization are people over the age of 50.[18] Among those individuals, the risk of poor outcomes, included the need for mechanical intervention is over 20%. Death from COVID-19 infection is usually due to pneumonia and sepsis and would occur between approximately 1-4% of the population. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine

24. The care of people who are infected with COVID-19 depends on how seriously they are ill.[19] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen.

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

[17] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*, The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

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

[19] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2002), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

People with severe symptoms may require ventilation and intravenous antibiotics. Southeastern Michigan hospitals are already overwhelmed and beyond capacity to provide this type of intensive care. This will worsen as COVID-19 becomes more widespread in communities.

25. In order to reduce the burden on the local health systems, aggressive containment and COVID-19 prevention is of utmost importance. To this end, the State of Michigan and the City of Detroit have mandated COVID-19 prevention strategies, such as "shelter in place" or "stay at home" orders, which have gone beyond containment and mitigation. Jails and prisons already have difficulty with containment because it requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. However, even with these efforts, it is nearly impossible for jails and prisons to provide the atmosphere of "shelter in place" or "stay at home" social distancing, given the number of individuals that work in and are housed in these facilities in the current system.

26. The time to act is now. Data from other settings demonstrates what happens when jails and prisons are unprepared for COVID-19. To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[20] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in the Wayne County Jail-Divisions I, II, III

27. In preparing this report, I have reviewed the declarations of present and former Wayne County Jail detainees Blanks, Carline, Hubbard, Kelly, Malec, Mathews, Nickel, Pearson, Russell, Smelley, Velez, C. White, and H. White.

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[20] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-preparecoronavirus-federal-prisons-providing-significant/story?id=69433690.

28. Based on my expertise in virology, my review of the relevant literature, and my review of the declarations referred to in paragraph 27, it is my professional judgment that all three divisions of the Wayne County Jail ("Div. I:, "Div. II", "Div. III", respectively, and the "Jail," collectively) are ill-suited for and dangerously unprepared to prevent and manage a COVID-19 outbreak within the facilities. As a result, the individuals inside of the Jail, as well as the staff who come and go from the facility, and, in turn, the broader community, would suffer severe harm and, in some cases, death. The reasons for this conclusion are detailed as follows.

29. Declarants state that the Jail is routinely admitting new detainees who are held in a unit with multiple detainees in cage-like cells for only a few days, not the full 14 days required for a medical quarantine. Declarants also remark that although each detainee is placed in his own cell, air flows freely between cells, and detainees share one shower and a telephone. The unit is not cleaned during the "quarantine" period, according to declarants. Then, the declarants state, detainees are transferred to a different multi-person unit without being tested, though at some point during the screening process their temperature is checked. If the declarants' representations are true, the Jail's intake, screening, and quarantine procedure is wholly inadequate and staggeringly ineffective against preventing the risk and spread of infection. Failing to test for COVID-19 means that the Jail cannot identify asymptomatic or pre-symptomatic individuals. While monitoring whether an individual has a fever, is certainly important, in order to limit the spread of the virus, facilities must also recognize the significance of the spread of COVID-19 from asymptomatic or pre-symptomatic individuals. An individual can present without a fever or respiratory problems and still be infected and infectious. Failure to consider these carriers results in dramatic undercounting of who may be exposed to COVID-19, and, in turn, results in inadequate mitigation measures. At base, it evidences a failure to observe the most basic preventative measures.

30. Declarants also said that detainees who have been exposed to infection are routinely transferred from one unit to another. If that is true, it dramatically increases the risk of a widespread outbreak and indicates that the Jail fails to practice the most basic mechanisms for mitigating the risk of infection. In order to prevent an outbreak, any persons who are infected or exposed to infection must be properly quarantined in

pressurized rooms, which stop the free flow of air and prevent the virus from travelling. Transferring detainees from one unit to another after they have been exposed to infection seriously increases the risk of spreading the infection to other areas of the Jail.

31. According to the declarations, depending on the Division, inmates are held in cells, rooms, or cubicles of up to four people, housed within units up to 40-50 people, and that in multi-person cells, it is impossible to maintain a distance of six feet. The declarants further attest to the fact that for most of the day, detainees congregate in a common area immediately outside of the cells, rooms, or cubicles, where they, typically, eat meals at communal tables or crowd in front of a television. According to the declarants, at the present population, it is impossible to maintain a distance of six feet from another person during meals and it is extremely difficult to socially distance in these circumstances. If detainees cannot achieve social distancing at all times, it is impossible to prevent the virus from spreading, regardless of whether the Jail implements any other protective measures. Without a vaccine, social distancing is the single most effective method of preventing or seriously reducing the risk of infection and spread of infection.

32. Declarants attested to the fact that individuals at the Jail are provided limited or no access to disinfectant and cleaning supplies. Specifically, the declarants stated that, in some cases, common areas and high-touch surfaces are rarely, if ever, cleaned with disinfectant. In other cases, according to declarants, they are cleaned as little as once per week and, at times, every other day. All common areas and high-touch surfaces should be sanitized with a disinfectant after <u>each use</u>. Failure to properly sanitize common areas and high-touch surfaces—such as the phones, tablets, tables, sink and shower knobs, and toilets— seriously increases the risk of the spread of COVID-19 and demonstrates the failure to take the most fundamental precautions for preventing the spread of the disease.

33. The declarants similarly attest to the fact that they do not have access to hand sanitizer, and, in some cases, they have limited or no access to soap or clean, running sink water. The declarants further state that they have limited or no access to paper towels and typically have to dry their clean hands on their uniform or the towel they use for

showering. Often, according to declarants, detainees use the same towel, uniform, and linens for one to three weeks. If the declarants' statements are true, it is clear that the detainees, through no fault of their own, are unable to maintain hygiene at the most basic level, which deprives them of some of the most important CDC-recommended measures to protect themselves.

34. The declarants also state that Jail staff provides no information to inmates about the risk the virus poses, particularly to vulnerable populations. Declarants further state that, in general, the Jail provides very little or no prevention guidance. And most declarants state that they are not provided with any information about possible symptoms and have had to rely on outside sources, such as the news, friends, or family members. Providing this information is crucial to preventing the spread of COVID-19.

35. Some declarants even state that Jail staff advises detainees that they are safer inside of the Jail than persons in the community. This is false, and, again, raises questions about the Jail's ability to understand the threat posed by the novel coronavirus and their ability to manage an outbreak.

36. The declarants also state that it is very difficult to get medical care in the Jail, even in the event of a medical emergency. They explain that Jail guards often do not take pleas for medical attention seriously, unless something catastrophic occurs, such as a heart attack or loss of consciousness. Declarants attest to waiting days, and up to two months, to have access to a medical doctor for serious medical concerns. Since two Jail physicians died from COVID-19, detainees state that they have not seen on-site doctors. And, although the virus is present in the Jail, according to the declarants and recent news reports,[21] declarants attested that the Jail continues to ignore or be dismissive of detainees' medical concerns. In some cases, according to the declarants, the Jail is threatening to discipline detainees when they request medical attention. If true, these practices make it more likely that infections will be underreported and unidentified, and, thus,

[21] *See* Ross Jones, Huge disparity among local jails testing for COVID-19, Channel 7-WXYZ Detroit, (April 30, 2020), https://www.wxyz.com/news/local-news/investigations/huge-disparity-among-local-jails-testing-for-covid-19.

undercounted. As a result, infected detainees will not be quarantined, therefore creating a heightened risk of an outbreak.

37. The neglect of individuals with acute pain and serious health needs under ordinary circumstances, as the declarants describe, is also strongly indicative that the facility will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic. The declarants attest to neglect of their serious medical conditions even under typical circumstances. It is unlikely that when the medical unit is strained both due to the further understaffing or additional burden from potential COVID-19 patients that it will be able to provide the care necessary for those with medical needs caused by conditions other than COVID-19.

38. Failure to provide individuals with adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection, as well as increased risk of infection-related morbidity and mortality if they do become infected. Plaintiffs and others held in the Jail have serious medical vulnerabilities, including but not limited to diabetes, asthma, hypertension, Hepatitis C, high cholesterol, cancer, sickle cell disease, and other respiratory conditions. According to the declarants, in many cases they are denied necessary medication or other treatment.

39. Also significant, the declarants who have tested positive for COVID-19 attest to the fact that placed in units with other infected individuals. They further stated that the Jail is regularly admitting newly diagnosed patients, and the populations are either commingled or housed in rooms where air freely flows. In most cases, the high-touch surfaces and shared spaces are rarely disinfected in these units, according to declarants. This is grossly inadequate and evidences the Jail's inability to effectively manage infection. Infected individuals must be quarantined from one another in negative pressure rooms. Failure to do so perpetuates the risk of an outbreak.

40. An outbreak in the Jail would be disastrous for Plaintiffs and other medically vulnerable individuals. Not only is it highly questionable whether these facilities have enough technology such as ventilators, personal protective equipment or medical personnel to treat serious cases of COVID-19, but it is also worrisome that, without proper

precautions, patients from the Jail will assuredly put additional strain on Southeastern Michigan medical facilities who anticipate bed and ventilator shortages[22] and will have to absorb patients from the Jail.

V. Conclusion and Recommendations

41. For the reasons above, it is my professional judgment that individuals placed in any division of the Jail are at a significantly higher risk of infection with COVID-19 as compared to the population in the community, given the housing conditions in the facility, and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

42. Without a vaccine, reducing the Jail's population to the point where social distancing can always be achieved is the only way to protect the health and safety of people detained in the facility and the public at large.

43. For the medically vulnerable—individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune systems, cancer, diabetes, hypertension, respiratory conditions, Hepatitis C, sickle cell disease) or who are over the age of 50[23]—immediate release is the only option. The detainees' inability to practice physical distancing at all times, coupled with the Jail's failure to properly screen, identify, and quarantine infection, and their widespread neglect of medical needs creates a meaningfully higher risk of death for these individuals.

44. From a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the

[22] Kristi Tanner, *New data shows how many beds, ventilators are available by region in Michigan*, Detroit Free Press (April 2, 2020), https://www.freep.com/story/news/local/michigan/2020/04/02/michigan-available-hospital-beds-ventilators-coronavirus/2866871001/

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

community not be placed in any division of the Wayne County Jail at this time. I am also strongly of the opinion that individuals who are already in this facility should be evaluated for release. A careful evaluation of procedural and housing guidance is also needed for those who remain in the facility during the "stay at home" mandate and possibly until the epidemic is contained.

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

46. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

Executed on this 2nd day of May 2020.

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ADAM LAURING, M.D., Ph.D

DECLARATION OF COURTNEY WHITE

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

1. My name is Courtney White. I am 54 years old. I have high blood pressure and high cholesterol.

2. I have been in custody at the Wayne County Jail – Division III ("Dickerson") since December of 2019. I was house in Ward 509 on C-1, but on April 22, 2020 I was moved to E-3

3. When I was in 509, I slept in an 8 or 9 by 15 feet cubicle with three other men. There is one bunk on each wall. It is impossible to maintain a distance of six feet from another person inside of the cubicle. It has 31 bunks upstairs and 31 downstairs. There were probably about 40 guys total in the unit. There are eight showers, eight bathrooms, and eight tables for everyone to share. During meals, 4-5 men sit at each table. It is impossible to maintain a distance of six feet from another person. The tables are not even six feet away from each other. And, when we are watching tv, everyone is seated close together.

4. E-3, where I am now, is set up in a similar way. There are two floors. There are 30 rooms downstairs and 30 rooms upstairs. There are approximately 45 guys here, and we each have our own room. The rooms have doors and windows, but they are not air sealed. Vents push air in and out. They have been blowing cold air, and it has very cold.

5. The first floor has a common area with tables. There are six tables for all 45 guys. When we're eating at the tables it is impossible to be six feet apart from another person. Some of the deputies have been letting us space out when we eat, but others don't, and it is not possible to wear masks while we're eating.

6. There are four sinks, four toilets, and eight showers for all of us to share. We do not have access to disinfectant of any kind, and no one cleans with disinfectant. We used to have access to disinfectant spray, but the jail took it away. Now we only have simple green, which is not a disinfectant, and we do not have any paper towel. We have to use c-fold napkins or rags from the laundry to wipe down common surfaces. The tables are sprayed down with Simple Green after every meal, but the phones, tablets, bathrooms and everything else is cleaned with Simple Green once daily at the most.

7. Lately, we have been getting as much soap as we want. They are little hotel-size bars that run out quickly. They dry our skin out really badly.

8. The inmates get one clean uniform and clean linens once weekly.

9. On or around April 11, the jail provided all of the inmates with masks, but we don't wear them when we sleep or when we eat. The jail staff inconsistently wears masks. Some wear them and some don't.

10. I am a trustee, and I work in the laundry room. I'm responsible for laundry for all three divisions plus juvenile. I worked in the laundry room with a man named Michael Meshinski. He was released from the jail at the beginning of April, and then died of COVID a couple of days later. Mr. Meshinski and I were not housed in the same unit. We only worked today. At the time we worked together, none of the inmates had masks, and he looked sick to me. He was coughing and blowing his nose. I would have to tell him to wash his hands after he coughed or sneezed.

11. To this day, I have never been tested for COVID-19. I am really scared because there are several guys in my unit who are on work release. They leave the jail for several hours a day, and then they come back to the jail and sleep here at night. I don't know where they've been or who they've been around. Every time they leave and come back, it puts us at risk.

12. There are a bunch of guys in here who are sick. We have been trying to get tested, but no one has gotten tested. It takes 3-4 days to a week to get a response when you ask for medical attention. Lately, if any of the inmates tell the jail staff they feel sick, all the jail does is give us Tylenol and, sometimes, they check our temperature.

13. Recently, I requested medical care because my left arm was numb. I still haven't seen a doctor. They only thing the jail did was give me tylenol. They have since taken me off of the Tylenol, and my arm is still numb.

14. The jail hasn't told us anything about coronavirus except that we should stay 6-10 ft apart. They know we can't really do that, though. They also put up a bunch of posters that instruct us to cover our mouths. It seemed like they did it because people were coming in for a tour.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Courtney White on April 24, 2020.

/s/ Allison L. Kriger
By: Allison Kriger Date: April 24, 2020

DECLARATION OF MARK MATHEWS

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

1. My name is Mark Mathews. I am 61 years old, and I have been at Division III ("Dickerson') of the Wayne County Jail since March 6, 2020.

2. I was brought to the Wayne County Jail from the Oakland County Jail, where I had been locked up since February 20, 2020. When I arrived at the Wayne County Jail I was taken to the medical unit because I was sick, and I recently had surgery on my pancreas. The medical staff took an xray of my lungs, and they took my temperature, but I was not tested for COVID-19. The medical personnel told me I had something on my lungs that looked like double pneumonia, and I was given antibiotics.

3. After I was given the antibiotics, I was put in general population on C-1, 117. Ever since I have been placed here, I have been really scared. I feel like I am going to die if I get COVID-19 because, in addition to having pancreas surgery and being diagnosed with pneumonia, I have hypertension and diabetes. The jail put me on a unit with 40 men, and it is almost impossible to be six feet away from anyone at any given time. A lot of the guys in my unit have been sick, but they're afraid to say something because they know they'll get locked in a room by themselves.

4. There are also several men in my unit who are on work release. That means that they go to work outside of the jail, and then they come back here in the evening. I don't know where they have been or who they have been around, and the jail hasn't tested them for COVID-19. As far as I know, none of the inmates in my unit have been tested. New guys are coming in all the time, and they don't get tested either. They get quarantined for 7 days, and they get their temp taken. That's it.

5. I have also complained to the medical unit that my chest was hurting. If an inmate's chest is hurting, he is sent to medical right away. When I went to medical, they kept telling me they couldn't really do anything, and that I had to see a doctor. No doctor was available.

6. We sleep in four-person cubicles. There is one bed on each wall, and they are approximately 2 ½ - 3 ft away from each other. It is impossible to maintain a distance of six feet from another person when we are in our cubicles, and we do not sleep with masks on.

7. All 40 guys share eight sinks, eight toilets, and eight showers. They are cleaned twice daily, regardless of how often they are used. The inmates can clean those areas whenever

we want to with Simple Green, but Simple Green is not a disinfectant. those spaces ourselves because we do not have access to disinfectant spray. We only have Simple Green, which is not a disinfectant, and we have to reuse rags or old towels to wipe stuff down.

8. During meals, all 40 men share a few tables. It is impossible to be six feet away from anyone during meals, and none of the guys wear masks when they're eating. The meals are served on trays by inmate trustees. They wear gloves and masks, but they touch a bunch of stuff before they touch our trays. We also use the tables to play games and hang out. The tables are wiped down after each meal, but not more than that.

9. We get new uniforms and towels once per week. We get as much soap as we want, but it's really drying. We use the same soap to wash our hands, our bodies, and our clothes, and we have to use our towels or uniforms to dry our hands. We don't have access to any hand-sanitizer.

10. The jail hasn't told us anything about corona virus. Everything we know is from the news.

11. We got masks for the first time a couple of weeks ago. They are blue cloth. We haven't received new masks since then. None of the inmates have gloves. The jail staff does not wear gloves, but some of them wear masks. They just started a week or so ago.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Mark Mathews on April 20, 2020.

/s/ Allison L. Kriger
By: Allison Kriger Date: April 20, 2020

DECLARATION OF CHARLES RUSSELL

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

1. My name is Charles Russell. I am 59 years old. I have been in the Wayne County Jail Dickerson Facility since March 20th, 2020. I am currently living division E1. Before this I was on division G1 where they do intake.

2. I have stage 3 prostate cancer. I am diabetic, have high blood pressure and an umbilical hernia that is trying to come through my skin.

3. I have not been taken to radiation treatments since being in the jail. I am supposed to go 5 days a week. The only medicine I have been given is Flomax.

4. I am sure my doctors are wondering where I am. I was in treatment Monday through Friday at 9:45AM before coming to jail. I see a radiologist and a urologist.

5. I need my treatment really bad. If I don't get it my cancer will probably spread. I was scheduled for a minimum of 50 treatment shots.

6. In the jail they say there is no doctor for me to see. They told me there is no one to take me to my treatments because so many deputies are out sick.

7. They tell us there are no doctors available and no doctors on staff in the jail. We just found out that two of the doctors that work for the jail have died from coronavirus.

8. I live on a pod. They just added 6 or 7 more people. There are 25 people now. They keep bringing new people into our pod from the outside. It makes me nervous because there is no way for them to know if these individuals have the coronavirus. They only thing they may do is take your temperature.

9. We all share the bathroom on my pod. There are 8 showers but only three work. There are 8 toilets and 8 sinks, 4 of the toilets are out of service. It's pretty sad.

10. People are on the phones constantly trying to talk to family. There are 8 phones on the pod that we all share. I am in charge of cleaning them. This is a job that I took on myself for my own health and protection and the health of the other inmates. I clean them three times a day some sort of cleaning liquid. There is no label so I don't know what it is. I have to ask the officers for gloves to clean with. One day we had no gloves. People were using garbage bags to cover their hands and serve our food.

11. Each day we get three meals. Until recently we got a cold breakfast and a hot lunch and dinner. Now we get a cold breakfast, a hot lunch and a cold dinner, 2 bologna sandwiches. I have a personal cup that I use that I bought from the commissary. I have had to make my

own disinfectant. I use shampoo, Irish spring soap that I brought from the commissary and a spray that I got. They give us soap but it's nothing like what you would buy at a store.

12. I don't know how much things cost exactly. I have a $45 dollar charge on my commissary account for an identification bracelet the jail requires us to buy. If anyone puts money on my account it will be taken to pay this fee so I ask other inmates to purchase my soap for me. I think it costs $1.65.

13. The only information we get is from the news. They haven't given us anything or any information, there is nothing even posted on the pod, but the officers protect themselves.

14. The jail is not as clean as it should be. We should get bleach to clean. Right now only the deputies have it and they keep it in a secluded area that only they can access. They won't allow us to clean our rooms with it, or even add it to the water that we mop with. They don't use it in the dining area either. They use a diluted cleaning soap for that. We use the same stuff to clean the floors, the bathrooms, the tables.

15. It is very stressful. I am waiting to see a judge but they have been putting my case off for weeks. Now they don't even know when I will go back to court. They only send a few people each day to court on video. It is like you have to wait for your name to be called.

16. I've had 4 dry runs to go to court. That is when there is a scheduled court date but I haven't been able to actually have my appearance. They keep telling me to be patient. The guards in classification told me that because I'm accused of a probation violation I'm a low priority. There are at least three others on my pod like me waiting to see a judge.

17. It is hard to do social distancing because we are always in contact. I'm scared every night. A lot of us are scared. After two weeks of suffering they took this guy to the hospital and two days later he died. There are a couple individuals who are sick on my pod. The guards don't believe people when they say they are sick.

18. Two weeks ago I had a bad headache, nausea, was feverish and stayed in bed all day. I spoke with the nurse and she said there was nothing she could do because there was no doctor. She didn't give me anything.

19. They just opened up a pod for coronavirus victims and they have them on oxygen. They are bringing them from downtown. They moved people out of a pod to use it for that.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Charles Russell on April 28, 2020.

/s/ Ashley Carter
By: Ashley Carter
Date: April 28, 2020

DECLARATION OF TERI NICKEL

I, Teri Nickel, certify under penalty of perjury that the following statement is true and correct:

1. My name is Teri Nickel. I am 36 years old. I was incarcerated at Wayne County Jail-Division One (also known as the "New Jail") from February of 2020 to March 30, 2020.

2. While I was in custody, I was in fear for my life due to Covid-19 because I have asthma, a thyroid condition, recovering liver failure, and a damaged heart valve. Inmates were being transferred from one unit to another regularly, and no one was tested or otherwise evaluated for Covid-19 at any time. The general narrative from deputies was "you're safer in here than you are out here," in response to any girls who complained about feeling symptomatic. I never saw or heard of anyone who received medical attention in response to these complaints. Instead, they were told they were "being dramatic." And, no one was ever quarantined from what I saw.

3. If an inmate feels sick, she has to fill out a medical kite. It takes anywhere from one week to 60 days to get a response.

4. I never received any information about Covid-19 from the jail staff until the last ten days that I was locked up. The jail turned the heat up really high one day, and one of the deputies told us that heat kills the virus. That was the only time jail staff told us about Covid directly. Otherwise, the only reason I knew about Covid-19 was from the news and telephone calls with family and friends and my attorney. The jail never gave us any guidelines or information, verbally or in writing, about how to stay safe, how the virus is spread, or what symptoms we should look for.

5. During the month of March, I was transferred from one unit to another a total of five times. I was never tested or evaluated for Covid-19. None of the inmates were tested or evaluated. The standard units are shared by either 10 woman or 20 women. There are two women to every cell, and each cell has bunk beds. The top bunk is only a couple of feet higher than the bottom bunk. So, it's impossible to stay six feet away when we are sleeping. About one foot away from the bottom bunk is a toilet without a lid that is one foot from the beds. Then, there is a make-shift desk right by the beds. The person in the top bunk has to step on that to get up to the bed. There isn't a ladder. I don't know exactly how big the cells are, but there isn't enough room to be six feet away from your cellmate.
   phone
6. Our cell doors are usually open all day. That was still true even in the last couple of weeks. Immediately outside of the cells is a common area that has metal picnic tables, a TV, tablets, and a phone, and there are showers nearby off to the side. I don't know how big

the common area is, but there definitely isn't enough room for everyone to be six feet apart. The unit with 10 women has three tables, and the 20-women unit has five tables. Everyone eats at those tables, and everyone uses the same tablets and telephone. I have only seen one deputy clean off the tablets and phone after each use, but otherwise, they are not cleaned.

7. The ventilation is very bad. There is usually a body odor or moldy water smell. The day that the jail turned the heat up really high and people were really uncomfortable, the deputies told us that the ventilation is really bad.

8. I never received any gloves or a mask, and neither did any of the other inmates, except the trustees when they were spraying disinfectant or serving food.

9. I have never seen how our food is prepared, nor have I ever assisted with food preparation. For breakfast, the trustees bring us carry-out containers at 5-6 am. They slip it under the bars. Then, at 10:30 am the trustees bring us food. They use gloves but no hair nets or masks. They give us plastic spoons that are all unpackaged in a flimsy plastic bag. We're told, "take one and pass it down." So, each girl grabs the bag, then reaches into the bag to pull out a single spoon. None of the girls wear gloves when they touch the bag or take a spoon. The process for the other meals we get during the day, is the same.

10. We also didn't have any hand sanitizer. Although we could essentially get as much soap as we wanted, it was hard to wash our hands because most of the sinks were unusable. The sink water is tied to your toilet water and also the toilet and sink of the cell next to you. If you don't flush your toilet for long enough, the excrete will flow to your neighboring cell's toilet. It made everyone not want to use the sink water. People didn't really wash their hands for that reason. And, many of the sinks aren't completely in working condition – e.g. the hot or cold water won't work, or they'll be too dirty to use. Sometimes they have maggots, fruit flies, or other bugs. I shared my sink with my cellmate as well as inmates whose sinks didn't work.

11. Generally, we were allowed to shower as much as we wanted, but all of us share only a few showers, and the area is not large enough to be six feet away from anyone else. The showers are filthy. They are sprayed down every other day, but if the inmates want them wiped down, we have to do it ourselves.

12. Each inmate got one roll of toilet paper twice per week. If there was a toilet paper shortage, they would not restock unless it was toilet paper day. And, we never got any paper towels. Once or twice a week, the deputies would slide a pile of c-fold napkins through a window into the common area. There was no established way to distribute them. Inmates could take as many as they wanted from the pile, so sometimes there weren't enough for everyone.

13. We don't have disinfectant to clean the tables or any other surfaces, such as the toilets, sinks, or showers. Every few days, the trustee would spray all of the surfaces with a bleach cleaner. They sprayed every other day during the last ten days that I was at the jail. The trustees did not wipe the surfaces after they sprayed. And, most of the time they missed surfaces, and I would have to instruct them to spray a surface that they missed like a toilet, sink, or shower. After the trustees sprayed, we used toilet paper or c-fold napkins, when we had them, to wipe the surfaces clean. Because the trustees only sprayed every few days or every other day, we could not disinfect any surfaces after each use.

14. Aside from the bar soap, we have to purchase hygiene products. On average, I spent about $10-$20 on hygiene products and clothes.

15. The staff started wearing gloves and masks around March 20.

16. The jail is not taking this situation seriously, and people are going to get very sick and possibly die. The inmates are feeling desperate inside. We are literally helpless inside.

_____ _____

TERI NICKEL DATE

DECLARATION OF DOMINICK KELLY

I, Dominick Kelly, certify under penalty of perjury that the following statement is true and correct:

1. My name is Dominick Kelly. I am 21 years old, and I am currently incarcerated in Ward 509 at the Wayne County Jail-Division II (also known as the "old jail"). I have been in the Wayne County Jail since March 31, 2020. I first got locked up in the jail on September 28 then I went to Ryan Correctional for a program, but the program was cut short because of coronavirus. There were a couple of people sick at Ryan.

2. I have asthma for which I am prescribed an Albuterol inhaler. I am also allergic to tomatoes, and the jail keeps giving me food with tomatoes.

3. When I arrived back at the Wayne County Jail on March 31, I was held in quarantine in the "new jail" for three days. The unit in which I was quarantined at the new jail had about 10 different 5x5 rooms all lined up next to each other. I was in a cell by myself, but they were not sealed. They were like cages.

4. The staff took my temperature when I got there, but I was not asked about my health otherwise. I wasn't asked any questions about how you were feeling, or whether you felt sick.

5. During the three days I was there, the Jail staff didn't mention anything about coronavirus.

6. During those three days, I was physically touched or at a distance of less than six feet from approximately six officers. Some wore gloves and others wore nothing. But no one wore masks. I also did not have gloves or a mask.

7. During meal service, the trustees came and served us food. They were wearing gloves but no masks. The food is served in a foam carryout type container. A jail guard opens the top and looks inside before they hand it to us. They never wore gloves or masks when they did that, and the box was about two feet from their face when they did that.

8. When we're done eating, the trustees come around to collect the trays.

9. My cell in quarantine had a single bed, and a toilet that doesn't have a lid. It's one foot from the bed. The toilet itself was clean, but if the toilet next to me is flushed then the excrement flows into the toilet in my cell. The sink looked clean.

10. During those three days, five inmates, including myself, shared one shower. The shower is not cleaned after each use. I didn't see it get cleaned one time in three days.

11. I was given a clean uniform in quarantine. I only got one bar of soap for three days. It's a hotel bar size. We use that to wash our hands and to shower. I would run out after one shower. In order to conserve, I broke the bar in half. I asked multiple times for soap, but the jail wouldn't give it to me. Apparently, they did not have anymore soap to give me.

12. I got one clean towel in quarantine. I did not receive a new roll of toilet paper. I used the one that was already in the cell that look like it had been partially used. We had no paper towel, no kleenex, no c-fold napkins.

13. In quarantine we have no access to cleaning products, and I never saw anyone clean the showers or phone or any of the other common areas like the tables or round bench stools.

14. During quarantine only one person is let out their cell at a time. We each have one hour. Nothing is cleaned between each person's hour outside of their cell.

15. After the three days of quarantine I was put in handcuffs and taken to the fourth floor of the new jail, the mental health ward. I was there for a couple of days. We can only have towels during part of the day. I was provided with a dirty mat and slept in a dirty cell. The mental health ward is filthy. The walls are covered in feces, pee, and vomit. You can smell the toilets. They're filthy. The sinks are filthy. The walls are filthy.

16. There is no hand sanitizer in mental health ward or in quarantine. We have access to soap in the mental health ward. I use the same towel to wipe off after I shower as I do to dry my hands. The only thing I have to dry my hands when I don't have a towel is my clothes.

17. There are 4 mental health rocks, with anywhere from 6 people to 13 people. You have a dirty mat and they give you two covers. There is one room where there is one bed. Otherwise, there are two beds and two people in each a cell. The beds are stacked bunkbeds. There is about 2 ½ -3 ft between beds.

18. The cells are open, but you go back in your room every 30 minutes. Each rock has one shower that all of the inmates share. I've never seen anyone clean the shower. They aren't cleaned unless the inmates clean them, but when I asked they wouldn't give me disinfectant. I didn't see anyone clean the phones off. This time when I asked for paper towel and spray they said they didn't have it. There are tables set up like in the quarantine rock but a little bit bigger. On the small rock there are three tables. The tables are not cleaned. Nothing ever gets cleaned on the mental health ward. Sometimes if you're lucky you get spray.

19. When I was on the mental health floor there were people coughing, throwing up, wheezing. Nobody was wearing masks or gloves. None of the inmates got masks anywhere in the jail that I saw until April 11. The mask is like a doctor's mask.

20. The mental health ward stinks. There is no air flow. My cell was right next door to a person who was sick. The cells have regular bars.

21. The inmates talked about coronavirus. One of the inmates said they had Covid, but I didn't know whether he was telling the truth.

22. Of the two days I was in the mental health ward, I saw more than five staff. Some were wearing protective wear. Others were not.

23. In the mental health ward, the trustees serve food. They serve it in the same way as they do in the quarantine rock. They had gloves but no masks. They slide the food under the bars.

24. Then I was moved to a rock on the new side. I was there for two days. There were 6 people all together, four of those five were people I had not previously been with. I was not tested for coronavirus.

25. I slept alone in a cell with a toilet and a sink. We have a limited amount of soap there. Everyone shares one shower. I've never seen it cleaned. I never saw any disinfectant, and never saw anyone wipe it down. We also share tables. In the two days I was there, the

tables were never cleaned. There is one telephone. It was not wiped down. None of the inmates had masks or gloves. Some staff wore masks and gloves and some didn't.

26. About a day after I got on that rock, I still had the same blankets, but I was given a different mat. It was better than the mat in mental health but not clean.

27. Jail staff still didn't talk about coronavirus.

28. A few days ago I got transferred to the old jail. I am in a single man cell with a sink and toilet. We are out of our cells from breakfast to 6 pm. The other inmates told me that someone on our rock got really sick before I came. He is not there anymore but his stuff is still in his cell. They took him to medical and never brought him back.

29. We haven't been able to shower in a couple of days because the shower is flooded. We get a couple of bars of soap every week, but they're the little hotel bars.

30. The tables are only cleaned if we clean them. They give us a bottled cleaning spray, rag, and a mop that they change once a week, but we only have access to the spray bottle once a day, in the morning.

31. There's one telephone for everyone to share. We can only clean it once daily – in the morning when we have the spray. Nobody comes in to clean.

32. When I arrived on the rock, no one had masks. The deputies serve us food on the old side where I am now. They inconsistently wear masks and gloves. Sometimes one or the other, sometimes nothing, and sometimes both.

33. The cell bars are not cleaned, and I have black mold in my room on the top corner on my cell.

34. The nurses come around if they need to pass out meds.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Dominick Kelly on April 16, 2020.

/s/ Allison L. Kriger
By: Allison Kriger Date: April 16, 2020

DECLARATION OF CARL SMELLEY

I, Carl Smelley, certify under penalty of perjury that the following statement is true and correct:

1. My name is Carl Smelley. I am 38 years old. I am currently incarcerated at the Wayne County Jail-Division II ("Old Jail") in Detroit, Michigan on cellblock 604. I have been in the jail since November of 2019.

2. I have hypertension, diabetes, sickle cell, and acid reflux. I'm scared of dying from COVID. Everyone around me is scared of dying and never getting to see our families again. Everyone in here knows that if they get sick, we're not going to get the medical treatment we need. We're the lowest people on the totem pole.

3. Regular requests for medical treatment take anywhere from two weeks to one month. And, that's if we get any response at all. It's not uncommon for the jail not to respond. There is a guy on my unit who is sick right now. He's been sick in the bathroom a lot. He asked for medical treatment, but the deputies just dismiss requests for medical attention.

4. No one has been tested. You have to almost be dead before they're going to consider testing or evaluating you. And, lately, the inmates have been scared to tell the jail staff that they feel sick because they have been responding with threats. The deputies tell us that if we complain about being sick they'll "quarantine" us, but what that really means is that we will get disciplined. A couple of deputies came by the rock after two guys were disciplined for talking about jail conditions to someone using one of the tablets. The video was released to the news, and the deputies were laughing, saying, "they [the inmates] got what they wanted. Now they're on 24 hour lockdown. They're safe"

5. I am in a one-person cell with a single bunk, a sink, and a toilet. The toilet doesn't have a lid, and it is approximately a couple of feet away from my bed.

6. Including me, there are five guys total on this cellblock. From 6:00 am to about 10:00 pm we are outside of our cells. We share one shower, one tablet, one phone, one bench for eating and the same bench for watching tv between all five guys. If we are all sitting at the bench, we're body to body. We are sitting so close to one another that we can't even put our elbows up.

7. The jail gave each of us one mask on April 11. It is a cloth surgical mask. We have not received a clean one since. When we are sitting on the bench for meals, no one is wearing their mask.

8. Meals are served on trays by the Deputies. Sometimes the deputies who serve food are not wearing masks and sometimes they are. They use gloves, but they are already wearing the gloves when they come into the unit. They use the same gloves to touch multiple surfaces before they touch our trays.

9. After we are finished eating, the tables are not sanitized. We don't have any access to disinfectant of any kind, so we have to use water and an old ripped towel to wipe the tables down. That is also true with the shower, phone, and tablet.

10. Jail staff comes in to clean the shower once a week or every other week. I have never seen the phone or tablet cleaned.

11. The inmates each get three two-inch bars of bar soap per week. We use that soap for washing our body, hands, and clothes because they only change linens and clothing once per month. If we run out of soap, the jail will not give us any more soap, even if we ask for soap. The soap that they give us is the worst soap ever. It dries my skin out. If we want any extra soap, we have to buy it through commissary. One bar of soap is $1.65.

12. We have no access to kleenex or paper towel. We only get one roll of toilet paper per week. We don't get more if we run out. The deputies said they were told they are only allowed to pass out one roll per week.

13. The jail hasn't given us any information about COVID or hung any posters. They only tell us that we are in the best position in here because we haven't been outside. Otherwise, the only way I know about COVID is from the news.

14. Commander Collins was on my rock right before he died. I know of multiple deputies who were on our rock who have been diagnosed with COVID. Still, some of the deputies do not wear masks or gloves.

15. On April 13, I was arraigned by video. I was handcuffed by a deputy who was not wearing a mask. He took me to the new jail where I was placed next to about four other guys who I had never seen before. None of us were wearing masks or gloves. Then, after the arraignment, I was taken back to the old jail and placed back on 604. I was not tested or otherwise screened for COVID before or after the arraignment. They did not even take my temperature.

This declaration was orally sworn to by Carl Smelley on April 22, 2020. Because he is in custody, I am unable to obtain his signature.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Carl Smelley. on April 22, 2020.

/s/ Allison L. Kriger
By: Allison Kriger Date: April 22, 2020

DECLARATION OF SHANE CARLINE

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

1. My name is Shane Carline. I am 33 years old, and I have been at the Wayne County Jail since January of 2020. I am currently being housed in Ward 509 at Division II (also known as the "old jail").

2. I am in a one-man cell.

3. I have hepatitis C, and I have a high liver enzyme count. So, I am more suspectable to infection. I have not been given any medication.

4. There are three guys on the rock. We had a fourth, Davonte Velez, but he was taken out because he was sick. He was sick for four days before he was removed from the rock. We didn't have any masks at that point.

5. Until April 17, Mr. Velez's personal belongings was still in his cell. I complained to the jail that Mr. Velez's stuff should be removed because it posed a health risk. In response, a deputy ordered me to clean it up. I was not given any gloves.

6. All of the inmates share one shower. On or about April 8 the shower flooded, and was unusable. We kept asking the jail to fix the shower, but no one came to fix it until April 15. No one was able to shower for those 7 days. While the showers were out people were taking bird baths.

7. Food is served at the only table on the rock. That's where everyone eats. Although we have masks, we all take them off to eat, and we are only a couple of feet away from each other.

8. The deputies serve food. They wear masks and gloves, but they touch a number a number of surfaces with the gloves that they use to touch the food boxes that they hand to us. They use those gloves to touch the cart that they bring the food trays on, the juice they hand us from a milk crate.

9. We only have access to cleaning supplies once in the morning. We get a mop, a bucket with disinfectant, a broom, and a dustpan.

10. All of the inmates share one tablet and one telephone. We don't have any way to clean the tablet or phone after each use. We can only clean them once daily.

11. We were given masks on April 10. They are cloth surgical masks. Some of the jail staff is wearing masks and gloves, but some are not.

    We're given three hotel bars of soap per week to wash clothes, hands, bodies. They are palm size, and it makes me break out with little bumps and what looks like psoriasis. If we run out, we have to ask another inmate. The jail won't give us more soap, and we don't have access to hand sanitizer.

12. We wash our clothes in the sink or shower. I use the same towel to dry my hands as I do to shower. We get a clean uniform once weekly, but sometimes it is every two weeks. Laundry has been inconsistent. This week, for example, we got new towels but no new blankets. We've had the same blankets for three weeks.

13. No one has been tested for COVID. I know of only one person who was screen and that was done by taking his temperature.

14. A couple of weeks ago, I tried to commit suicide. I swallowed a bunch of meds. I woke up in the hospital. The deputy who escorted me wasn't wearing any protective wear the entire time. When I got back to the jail, I went to the mental health ward where I was locked down for 24 hours to make sure I wasn't suicidal. Then I was put back in general population without any testing or screening.

15. The Jail isn't telling us anything about COVID. When I ask about COVID they dismiss what we have to say. When inmates say they are scared or in fear of getting sick or dying, the deputies tell us that we are in the best place possible. One deputy told us that he had been exposed to people with the virus but hadn't caught it.

16. A week and a half ago, the jail hung signs on the bars saying "use a tissue for coughs" and "avoid touching your face." We have no tissue, but we have toilet paper. However, we only one roll per week, and if we run out we are told that we cannot get anymore. We have to borrow extra from our neighbors.

17. To put in a request for med attention, you have to fill out a medial kite. You can do it once in the morning or once at night. Then, you have to wait for someone to respond. It took the jail two and a half weeks to respond to my request about my hepatitis condition.

18. Nurses come in the morning to distribute medication and at night. Sometimes they don't bring medication at all. The medical staff is wearing gloves and masks, but when they distribute medication, they use and reuse the same cups for multiple inmates. At times, the medical staff does not pay attention and passes out incorrect medication.

19. In terms of staffing levels, I have noticed the deputies are coming around less. Usually they make rounds every 30 mins, but lately it's been every two hours.

20. People are in fear for their lives. We hear all of this horrible stuff on the news, and we People feel like they're not being protected.

21. The conditions in here are horrible. There is lead paint chipping off the ceiling. There's black mold in the showers. All around the drain in the shower is broken.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Shane Carline on April 22, 2020.

/s/ Allison L. Kriger

By: Allison Kriger Date: April 22, 2020

DECLARATION OF SHOKELLE MCKAY

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

1. My name is Shokelle McKay. I am 26 years old. I am currently incarcerated in the Wayne County Jail, Division II. Before this I was in Division I.

2. I was in Division I, Unit 1409 when I first got to the jail. I was there from about March 10 – 17, 2020. We slept in bunks. It was an open setting with tables and bunks. Eleven people fit there. We did not have masks or gloves. Meals were brought to the unit and everyone waits in line to grab their own tray. We could either sit on our bunks and eat or eat together at a table.

3. There was one phone. There were 10 people using that phone.

4. I was in the jail about 4 or 5 days when I started feeling sick. I used the phone after someone coughing used it. I know that he was coughing bad. There weren't supplies available to clean the phone. Usually people used their shirt or a sock to clean and cover the phone.

5. I started to feel funny and sick sick almost immediately after using the phone after the guy who was a sick. At first it was a scratchy throat and through the night it got progressively worse. My throat was hurting more and more. I had shortness of breath and a very serious mucus build-up. The nurse came through the unit two times per day. I asked for a kite and filled it out but nothing happened. I felt sick for at least 2 weeks. There was no real medical care and I was never tested for COVID-19.

6. I was sick in Division I for 3 days before I was moved to Division II.

7. After being moved to Division II I was there for two weeks when I started to feel better but I was still coughing really bad at night and there was still a lot of mucus. When I asked a nurse for help and for a kite to fill out I didn't get one. It is really hard to get a medical kite. Mostly the nurses just pass out the medication.

8. They moved two people from the street into our unit. Shortly after they arrived people started getting sick. I had a fever. I started feeling hot so I asked the nurse to talk my temperature and it was 99 degrees. She said she was going to come back and take it again but she never did. After that, the next day I couldn't taste or smell and I had shortness of breath. This lasted 4 or 5 days. There was no medical care.

9. I knew about the virus but I didn't think it could affect the jail this much.

10. The jail is horrible. It's real dirty. There is no system or place to do laundry. They are supposed to do a linen exchange. When you come into the jail they give you green pants and a green top. They don't give out underwear. They are supposed to change the linens and clothes weekly and they don't.

11. When I first got here they didn't do the exchange for a month. I asked them to change it but no one really cares. They come when they come. We have to wash our underclothes in the sink. We have to drink out of the same sink when we want water. They give us three bars of hotel-sized soap and a roll of toilet paper every Tuesday in Division II. You have to use the soap to wash your body. If you also use it to wash clothes it won't last. If you ask for more from the deputies they say no.

12. I only got information about coronavirus after I was sick. I got a COVID-19 information page. The nurse explained a little bit to us. Before I was sick they had given out masks that were supposed to be used for one day. We had to use them for 11 days.

13. On the unit I'm on now we each have a cell with a bed, desk, toilet and sink. There is one shower that 11 people share. Trustees come in and clean it every now and then. There is no set schedule for cleaning the shower. Towels are supposed to be changed every week but it's been at least 2 or 3 weeks. We don't have a washcloth, just a towel.

14. They have turned my unit into a sick ward. Everyone is covid-positive. Medical comes here every so often, mostly once in the morning and once at night. They check your heartrate, blood pressure, temperature if you want and give you Tylenol.

15. They bring our meals to the unit. The guards pass them out.

16. The deputies and trustees that come on our pod sometimes wear gloves and masks, and sometimes they don't.

17. We all share a common area. It is about 3 feet by 20 feet. It is really narrow. There is one phone and one TV that we all share. If you have money you can use a tablet to watch other programs. There are 4 tablets.

18. The jail said that we would get free phone calls and tablet calls. We were supposed to get 2 free 5 minute calls on Tuesdays. But the day we were supposed to get the free video calls the tablets did not work.

19. We don't have cleaning materials. There is a broom and a mop. Sometimes the mop bucket is filled with dirty water. They don't change mop head. There is no toilet brush. There is a green solution that is stored in a closet. We don't get it often, maybe once a week, if that. The deputies control the closet. It is outside of the unit. They don't pass out paper towels. In order to clean you would have to tear your towel to create a cleaning rag.

20. There is no way to quarantine here.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Shokelle McKay on May 3, 2020.

/s/ Ashley Carter
By: Ashley Carter
Date: May 3, 2020

DECLARATION OF MARLON BLANKS

I, Marlon Blanks, certify under penalty of perjury that the following statement is true and correct:

1. My name is Marlon Blanks. I am 26 years old, and I have been in custody at the Wayne County Jail since April 7, 2020.

2. I have COVID-19, and I am scared I am going to die because I have severe asthma. I have a prescription for an inhaler to control and treat my asthma, but the jail has refused to give it to me. I have repeatedly asked the deputies and medical staff for my inhaler but they dismiss my requests. One deputy told me to "fuck off" and a nurse responded that "I didn't know what I was talking about."

3. When I first arrived at the Jail, I was held in "quarantine" for four days on the 11th floor of Division I (the "New Jail"). There were 8-10 other men in the unit, and although we each had our own cell, air freely passed between cells. No one was tested, no one was wearing masks, and at least two new detainees were brought into the unit while I was there.

4. For whatever reason, after the first night, I was moved to a different cell within the unit, and after the second night, I was moved again, but I remained in the unit. The sink in the first cell was unusable because the sink and toilet water were connected, and the sink water appeared to be tainted with fecal matter. The sink water in the second cell was greenish in color, and the basin smelled moldy.

5. All the men in the unit shared two tables, a shower, and two phones. Even though one of the guys in the unit was ill, we had no access to cleaning products, and the jail staff did not clean any point.

6. During the first day, we were out of our cells for about six hours. The following three days, we were only out for about an hour. The Jail provided us with two two-inch bars of soap, but because we had so little time the last three days, I had to choose between showering and calling my family to check in.

7. The deputies were responsible for serving food. Only one in three wore masks and gloves. For the first two days, we all ate at the tables. It was impossible to maintain a distance of six feet from any other person. The last two days, we ate in our cells.

8. On or about April 11, I was transferred to Division I (the "Old Jail"). I received a new uniform, but I had to use the same towel and linens that I was provided in Division I.

9. I am now in the coronavirus wing on the 14th floor of the Old Jail. There are about ten guys in this unit. Everyone in the unit has tested positive for COVID-19, and the Jail is bringing new guys in all the time. They also have the virus. I'm not sure how we are supposed to get better if they keep doing that.

10. I am in a one-person cell, but we share one shower, a couple tablets, and a phone. There is a television in the unit, but there is no seating, so we all crowd around the television on the floor or standing up leaning against a railing. We all have masks, but some of the guys don't wear them. None of us have gloves.

11. The unit has only been cleaned once in two weeks, and we don't have access to disinfectant. Every morning, we get a mop bucket with the same water from the day before. I'm not sure whether the Jail puts any disinfectant in the water.

12. The Jail provides us with soap once weekly. Everyone always runs out, but the Jail won't give us more, even if we ask. We do not have access to paper towel, so if we wash our hands, we use our towel or uniform to dry them. We only get no more than one roll of toilet paper weekly, and we do not have access to hand sanitizer.

13. I have only gotten one new uniform since I was transferred to Division II, and I have not received a new towel or new linens.

14. Initially, the Jail staff didn't tell anyone in the unit that we were infected with the coronavirus, and we didn't think to ask until we noticed the deputies wearing hazmat suits and infrequently doing rounds. When we asked the Jail staff what was going on, they told us they turned our unit into the infirmary, but there is notable difference between our unit and any other. There's no medical equipment, oxygen, ventilators, and we aren't getting any medication.

15. The Jail hasn't given us any additional information about COVID-19, but a nurse posted a sheet of paper up that lists COVID-19 symptoms.

16. We're all very concerned. The Jail seems to be hiding what is going on. Most of the time, the deputies are just dismissive, and they treat us like we're less than human. Some people have worse symptoms than others, but no one is getting any real medical care. We are all scared of dying.

This declaration was orally sworn to by Marlon Blanks on April 28, 2020. Because he is in custody, I am unable to obtain his signature.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Marlon Blanks on April 28, 2020.

/s/ Allison L. Kriger_____ April 28, 2020
ALLISON L. KRIGER DATE

DECLARATION OF CHRISTOPHER HUBBARD

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

1. My name is Christopher Hubbard. I am currently incarcerated in the Wayne County Jail Dickerson facility. I am 26 years old. I have been in the jail since February 24, 2020. I currently live in unit E1. Before this I spent 14 days in unit F1 and 5 days in unit H1.

2. I am diabetic and I have asthma. I had pneumonia last fall, around October 2019. I have had pneumonia at least three other times.

3. When I first got to this unit I was placed in the cell Michael Meshinski was in, the guy who died from coronavirus. Another inmate told me that it had been his cell. I checked with a deputy who looked in the system and it was true. I asked to be moved right away. I don't think they even cleaned the room before I was moved there.

4. I got moved to another cell. I try to clean my own room. I use simply green and soap that I purchased from the commissary. The soap costs about $1.62.

5. On the pod we all share a bathroom. There are 8 toilets and 8 sinks. Some of the sinks are stopped up and all of the showers don't have hot water.

6. The inmates clean the bathroom. They are called unit workers. They use a green chemical called Simple Green. Every two weeks a corrections officer uses bleach to spray the bathroom. They don't use this bleach to clean the cells. The officers use Lysol to clean their own areas. We aren't allowed to use it for ours.

7. The common area is cleaned at night with simple green. There are 2 tvs and 12 small couches that we all share. We eat meals together, 4 people to a table. The table is about 4 ½ feet by 3 feet.

8. I don't think simple green works because if it did the officers wouldn't bring their own supplies. They bring Lysol, I saw one bring pine sol, they have other name brand supplies. They don't let us use it when we ask.

9. We got masks a few weeks ago but we don't have gloves. Some unit workers have gloves but they don't even have enough for all of them. A few days ago the guys serving food didn't have gloves and they were using plastic bags to cover their hands.

10. I got into an argument with an officer about my insulin and he put me in the hole for 7 days. It was around lockdown time when we are all supposed to go to bed. I asked if he could call the medical workers and ask about my insulin and inhalers because my blood sugar has been super high. He said he would get to it. I went to get water from the sink in the common area which is the cleanest one and he told me to go to the bathroom to get the water. I told him that this was messed up and that I was being medically neglected. I didn't

want to use the sink in the bathroom because it's dirtier and people leave stuff in it. He said if I didn't like it then I shouldn't come to jail. I told him that just because we are here doesn't mean that they can treat us poorly and deny our medical needs.

11. The hole is even more messed up than other parts of the jail because it's where they have people who are showing symptoms of coronavirus.

12. There are individual cells and it is packed down there. You can hear people coughing. You can see officers really suited up, like covered from head to toe. There are showers but the water is so cold you can't really use it. They are supposed to let us out for an hour each day but they usually don't.

13. The hole does not smell good. It smells musty and in the cells it feels damp like a basement. There were probably 17 people down there when I left. Inside my room was a bed, toilet connected to a sink, a small mirror and a window that I could not see out of. I saw mice and roaches down there.

14. In the hole they don't really change our sheets or do the laundry. They are supposed to do it once a week but they don't.

15. They give us food through a slot in the door.

16. When I was in the hole I felt pissed, sad and mad. I was depressed and worried.

17. They are supposed to check my blood sugar at least one time per day. They've gone from testing once a day to once a week.

18. I spoke to a nurse who knows I'm supposed to get insulin. In here they give me a pill that is different than what I take outside of the jail. The nurse said that if it makes me feel funny I should stop taking it.

19. I need insulin coverage and the correct inhaler. I requested a steroid inhaler and they keep bringing an albuterol inhaler. If my blood sugar gets too high I could go into a diabetic coma.

20. Outside of the jail I usually go to the doctor once a month. I try to work out a lot and try eat healthy. The food they give us here has a lot of starch and causes my blood sugar to be raised.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Christopher Hubbard on April 27, 2020.

/s/ Ashley Carter
By: Ashley Carter
Date: April 26, 2020

DECLARATION OF CALDERONE PEARSON

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

1. My name is CalDerone Pearson. I am 30 years old. I am currently incarcerated in the Wayne County Jail Dickerson Facility.

2. Until April 27th, 2020 I was a trustee in the jail, I worked in the laundry room. I usually worked from 7:30AM to 2PM. During my shift there were 8 or 9 workers and 2 supervisors. They bring the laundry from all of the jail facilities to Dickerson to be cleaned, including from the facilities downtown.

3. Being in this jail gives me a lot of anxiety, I am always thinking about if I have the virus. Sometimes I feel like I am having a hot flash because I am so anxious.

4. No one in the facility has been tested.

5. There was one guy on my pod when I lived in E1 who was sick for at least two weeks and I'm pretty sure he was sick with the virus. He was coughing and vomiting every day. The nurse would come to our pod and give him Tylenol two or three times a day. He went to the medical unit at least twice and they kept sending him back to the pod. After lockdown each night you could hear him coughing throughout the pod. It was so loud it sounded like a dog barking. He was finally taken out and he died a few days ago.

6. On E1 there were about 30 men on my pod. We shared a common area that is about 20 x 20 feet. It is impossible to stay six feet away from other people in the common areas. We shared the same tables at meals, three to a table, and watch TV in the common area.

7. We all shared the same showers and the same toilets. There were 4 showers and 2 toilets on my floor.

8. Until April 27th, our food was prepared by other inmates. One day two of the cooks came out and said they haven't been able to taste or smell. The cooks do not wear face masks while they are making our food. One of the civilian workers in the kitchen had coronoavirus. I think she had to take time off to recover.

9. On E1 there were 6 pod workers. Two pod workers serve the breakfast trays to the other inmates.

10. We were constantly asking for masks. Some of the guys have asthma and COPD. One guard tried before we finally got them but was told no because the masks have a small metal piece.

11. When we finally got masks we were told we had to keep them for two weeks. After one day they were worn down and used. The masks they gave us are blue on the outside and white on the inside. They look like a surgical mask. I asked about getting N95 masks and the corporal said to me "if we don't have those masks why would you?"

12. Some of the deputies don't wear masks, but they tell us if we don't wear the masks we will get locked down.

13. At least ten guys were sick when I was on E1 pod. One day they were fine, and the next day they were so weak they could hardly walk and looked like they were about to fall over. This lasts about 10 days and then they seem to start feeling better.

14. There was a nurse who came to our pod to bring people their medicine. Every time she told us not to talk to her unless we already receive medicine. She gave us a hard time if we tried to ask for help. Some of the inmates try to argue with her but she always says the same thing. In order to get a medical appointment we have to fill out a request form, called a kite, and she won't give us the forms. She will tell us to get out of line.

15. The guards in my unit wear masks and gloves. One guard even had on a hazmat suit. When they come in to the pod they spray their computer and desk with Lysol. When we ask to use the Lysol to clean our own cells they tell us no.

16. We have not heard anything about COVID-19 from the jail staff. Everything I have learned about this disease has come from watching TV.

17. If anyone has any symptoms of the disease they are given a Tylenol and sent back to the pod.

18. I was moved to Unit G1, cell 115, where they put people during intake. The cell was disgusting so I asked for cleaning solution. There was dried urine in the toilet. The whole cell smelled like urine. The toilet bowl is white but has turned orange because of the dried waste. There was hair everywhere in the cell and the floor, and in the sink. There were many short pieces of hair. I asked for a mop and a toilet brush to clean the cell. The guard told me to use C-Folds, those are the paper towels. We have to ask every time we need to use them. He said I should use those to clean the toilet with my bare hands. After I asked for more supplies the guard got irritated and said here just take the bottle of the cleaning solution and gave me the simple green. I don't think simple green works. If it did why don't the guards use it to clean their stuff?

19. When I started sweeping I noticed small black bugs popping up off the floor in the cell. I went back and asked the guard to move me. Then I moved to cell 116. I then tried to clean this cell with the same broom and saw more bugs. I asked to be moved again and the guard said I couldn't move. I asked to speak with the sergeant, he came and said I was disobeying an order and I was moved to segregation. In segregation there

was no hot water there to take a shower. I asked to get cleaning solution and all they gave me was simple green.

20. I was in segregation for three days. It is 23 hour lock down and you stay in your cell all day. There is no access to commissary and you can't use the phone. They give you your meals through a slot in the door.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to CalDerone Pearson on April 30, 2020.

/s/ Ashley Carter
By: Ashley Carter
Date: April 30, 2020

DECLARATION OF MARK MALEC

I, MARK MALEC, certify under penalty of perjury that the following statement is true and correct:

1. My name is Mark Malec. I am 38 years old. I am currently incarcerated at the Wayne County Jail-Division III ("Dickerson") in Hamtramck, Michigan. I have been in the Jail since January 12, 2020. From January 12 to April 20, I was in in cellblock E-1. On April 20, I was diagnosed with COVID-19, and was moved to a different unit.

2. I have asthma, low blood sugar, and kidney problems. I recently had surgery to remove kidney stones, and I have a fractured spine for which I am prescribed medication. On April 20, I was diagnosed with COVID-19.

3. The Jail hasn't given us any information about COVID-19. At the beginning of April, they started making announcements every day at 4:00 pm. They told us to maintain social distancing, but then they would acknowledge that they knew that wasn't possible. They also told us that we should wash our hands, but, when they first started telling us that, one of the deputies commented that he knew we were out of soap. It is common for us to run out of soap. Lately, however, the Jail has been keeping soap in stock.

4. After I learned about COVID-19 from the news and from my girlfriend more than a month ago, I was really scared. The Jail has done almost nothing to protect anyone. They still aren't doing enough. That's why I am not at all surprised that I got COVID-19.

5. In mid-March, Michael Meshinski, a guy in my unit who worked in the laundry department and was responsible for laundry for the entire Jail, started coughing constantly and all over the unit. This lasted for about three weeks. At that time, there were about 50 of us inmates living in E-1, and none of the inmates had masks or gloves. We all had our own cell to sleep in, but during the day were all packed together into a common space with bad ventilation that makes it almost impossible to get six feet away from anyone at any given time. All of us share showers, toilets, sinks, telephones, tablets, and tables. Those surfaces are cleaned by the inmates with a green spray only twice a day, once at 2:00 pm and once at 10:00 pm. The spray is Simple Green, which is not a disinfectant.

6. During the three weeks that Michael was coughing, he was taken to medical a few times, but he always came back to our unit that same day. On or about April 1, a deputy came in and looked at Michael, and seemed to notice how obviously sick he was. The deputy said something about Michael needing to go to medical. After that, he left our unit and never came back. A sergeant came to our unit, sprayed Michael's room down, and took all of his stuff out. We asked the Sergeant, "did he have COVID?" and the Sergeant responded, "I can't confirm that and I can't deny that."

7. After Michael Mishinski died, the Jail responded to the news coverage by saying that we all had masks. That was completely untrue. The first time we ever got masks was on April 9. They are cloth masks like you see at the dentist office. They told us we have to use these

for two weeks, and then after two weeks, we can get a clean one. The Jail also publicly said that nobody in here has any symptoms. That is also completely untrue, and they know it.

8. A lot of the guys have been sick throughout the past several weeks. I first started feeling sick in early April. I had head aches and I wasn't able to taste anything for a couple of weeks. I've also had a cough and a cold and was coughing up black phlegm. When I first started feeling sick, I complained to the guards, and they told me to tell a nurse. I told the nurse that I thought I had the virus. She asked if I had a fever, but she didn't take my temperature and didn't test me. She gave me Tylenol. The medical staff gets hostile if the inmates complain about feeling sick, and their response is always that we should take Tylenol. One of the guys in my unit complained a few times, and never got any medical attention. And, there's another guy in my unit with cancer who hasn't had any treatment in over a month.

9. I kept telling the guards and nurses that I was sure I had COVID-19 because of my symptoms. They didn't test me until April 20, and I tested positive for COVID-19. I have been in what the Jail calls "quarantine" since then. Really, it's just a regular unit but no one can come out of their cell, except for once a day. The Jail keeps bringing more sick people into the unit, so we keep getting exposed to the virus again, and I feel like I won't ever get healthy. We are not in any kind of pressurized rooms. The air just passes freely from one cell to the other.

10. The deputies hand out meals, which we eat in our cells. Some of them wear gloves and masks and some of them don't. All of the detainees wear masks but not gloves, and we all share tablets, phones, and showers. They are cleaned with Simple Green after each use, but with disinfectant only once weekly.

11. The Jail has not provided any real medical treatment for COVID-19 patients. We have not seen doctors, and there is no special equipment. We are getting Tylenol, cough syrup, and Gatorade. We are all still scared to death.

12. I'm not even supposed to be locked up anymore. I completed my sentence to the jail plus program, and I don't know why I'm not out yet.

This declaration was orally sworn to by Mark Malec on April 28, 2020 because he is in custody, I am unable to obtain his signature.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Mark Malec on April 28, 2020.

/s/ Allison L. Kriger
ALLISON L. KRIGER

April 28, 2020
DATE

DECLARATION OF HARRY WHITE

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

1. My name is Harry White. I am 36 years old. I have been in the jail since February 2020.

2. I have a bullet on my spine and a heart murmur. I suffer from paralysis where sometimes I lose feeling in my feet and hands. I can't stand or walk for long.

3. I am currently on pod E3, one of the workers pods. Before this I lived on G3, another workers pod. This is where people in the work release program live. It's pretty nasty. The floors and walls are dusty. About 5-7 men left every day to go to work and then they return back here. It was an open pod. There was an open area with 4 beds. We all shared the bathroom, about 45 of us. There were 4 bathrooms with showers on the upper level and 4 bathrooms with showers on the lower level. Before C1 I lived on G3.

4. They gave us a paper mask that only gets changed every two weeks. The mask tears easily, it's the cheapest mask you could ever wear. Once you wear it it tears on the sides.

5. I bought my own soap. They have some soap that they give people but you have to ask the officers for it at their desk. We don't have access to paper towel, we have to ask the guards for napkins and for toilet paper.

6. There is a guard on my pod who had coronavirus. He came back but he still seems sick and shows symptoms. You can hear him coughing all night long.

7. I've been kiting to the doctors but I haven't seen one yet. I send a kite every day. I don't think the nurse turns them in because there is no doctor.

8. When I had a tooth cracked I was sent to the dentist. She gave me an ibuprofen and said to let her know if I wanted it pulled.

9. I need medicine to help me for pain and also for my nerves because of the bullet on my spine. With the pain it is hard to move around. The pain feels like pins in my hands and feet. The only thing they give me is one ibuprofen and tell me to see a doctor but there isn't one.

10. When I'm not in jail I go to the doctor frequently, like every week. I'm supposed to start physical therapy. After I was shot I had to learn to walk again. I was supposed to be placed on a medical floor but it never happened.

11. When I first got here I used to tell the deputies about my pain every day. They said if you aren't dying you're not going to see a doctor.

12. I see coronavirus on TV and keep hearing someone in the kitchen died. When the guards hear something bad coming from the TV they unplug it.

13. No one has been tested for coronavirus.

14. I'm nervous and scared to be in the jail. If I catch any disease I don't know if I'll make it because of my heart murmur.

15. I can feel things getting worse. I was taking meds for my nerves, without it it's hard for me to get out of bed. I'm supposed to take it three times per day. When I wake up my hands and feet are numb. When I try to walk it feels like my bones are cracking. I've noticed I've started to walk with a limp. All they've given me is ibuprofen.

16. Some days I miss breakfast or lunch because I can't get out of bed. I had a surgery in my stomach to try and remove the bullet. The doctors told me I have to be careful because of where the bullet is on my spine.

17. If I get sick or catch corona I won't last long in here. They are treating us worse than animals.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Harry White on April 28, 2020.

/s/ Ashley Carter
By: Ashley Carter
Date: April 28, 2020

DECLARATION OF DAVONTE VELEZ

I, Davonte Velez, certify under penalty of perjury that the following statement is true and correct:

1. My name is Davonte Velez. I am 26 years old, and I have been in custody at the Wayne County Jail since March 26, 2019.

2. I have asthma for which I was prescribed an albuterol inhaler before I was detained. And, in the past my asthma has been so bad that I have had to do a breathing treatment. I have not had an inhaler since I got locked up. I've asked the jail for it, and my family has called, but the Jail won't give it to me because it's not on my medical sheet. I am terrified because I tested positive for COVID-19 earlier this month and again a couple of weeks later.

3. I started to feel ill on April 2, 2020. I was in the "Old Jail" at the time, and no one had masks or gloves. I spoke to one of the deputies, Officer Peoples, and he told me that I should lie down.

4. I consistently asked for medical treatment for the next five days. In addition to telling the guards about how I didn't feel well, I also filled out medical kite, and spoke to a nurse about how I felt. I said that I had shakes, that I was coughing, and that I didn't have an appetite. In response, she gave me Tylenol, but she did not check my temperature, nor did she test me for COVID-19.

5. Finally, after five days, on April 7, I spoke to the deputy on duty. He took me in the hallway and called a nurse who took my temperature. It was 103.

6. I was taken to the medical unit at the "New Jail." I waited in the waiting room for approximately two hours, after which I was transported to Dickerson.

7. I was initially placed in segregation. There were about three us there. Then, I was moved to CMU, the medical unit. There were about five other men in that unit, all of whom were sick. We all shared a shower, but we were essentially unable to use it because the hot water didn't work.

8. Shortly after I arrived, CMU flooded with toilet water so we had to move to H-3.

9. There are approximately 11 men in H-3. We are locked in our rooms for 23 hours per day. They Jail lets us out for one hour per day. They stagger us so we are all out at different times. Outside of our rooms, there is a common area with tables, a shower, tablets, and phones. Everyone shares those things. The unit is cleaned before the next person comes out, but the Jail uses only Simple Green to clean, which is not a disinfectant. I have never seen anybody clean with bleach or lysol or anything like that.

10. The Jail doesn't tell us anything about COVID-19. The Jail didn't even tell me I had tested positive for the virus until two weeks after I was transferred to Dickerson. When I asked why they waited so long to tell me, the Jail said two doctors had died so they have to send all of the records to some doctors in Atlanta.

11. Recently, I was tested again, and I still tested positive for COVID-19. There is another guy in H-3 who has tested positive three times since April 6. I'm really scared because I know this virus can kill people with asthma, and I'm not getting better. The virus is supposed to go away after two weeks, but I've been sick for almost one month. The Jail keeps transferring new sick men into the unit, and everyone has different symptoms. Even though we all have masks, I told the Jail that it seems like no one will get better if we keep getting reexposed to the virus.

12. Being locked in a room for 23 hours per day without being able to talk to anyone is causing me and some of the other guys to have psychological problems. For 23 hours per day I think about how I'm stuck in here with all of these sick people and I'm not getting better. When I try to ask the Jail staff about COVID-19 and what's going on, they don't give me any answers. It seems like no one knows what's going on and they don't have any system in place to deal with the pandemic.

This declaration was orally sworn to by Davonte Velez on April 29, 2020. Because he is in custody, I am unable to obtain his signature.

Under penalties of perjury, I declare that I have read the foregoing in its entirety to Davonte Velez on April 29, 2020.

/s/ Allison L. Kriger_____ April 29, 2020
ALLISON L. KRIGER DATE