IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

JOHN BAXLEY, JR., ERIC L. JONES,
SAMUEL STOUT, AMBER ARNETT,
EARL EDMONDSON, JOSHUA HALL,
DONNA WELLS-WRIGHT,
ROBERT WATSON, HEATHER REED,
and DANNY SPIKER, JR.,
on their own behalf and on behalf
of all others similarly situated,

Plaintiffs,

v. **Civ. Act. No. 3:18cv01526**
(Chambers, J.)

BETSY JIVIDEN, in her official capacity as
Commissioner of the WEST VIRGINIA
DIVISION OF CORRECTIONS AND
REHABILITATION, the WEST VIRGINIA
DIVISION OF CORRECTIONS AND
REHABILITATION, and SHELBEY SEARLS, in his
official capacity as the Superintendent of WESTERN
REGIONAL JAIL AND CORRECTIONAL FACILITY,

Defendants.

PLAINTIFF'S EMERGENCY MOTION FOR PRELIMINARY INJUNCTION
REGARDING DEFENDANTS'
PREVENTION, MANAGEMENT, AND TREATMENT OF COVID-19

Plaintiffs, on behalf of themselves and all others incarcerated in WVDCR custody, respectfully request that the Court order Defendants to immediately develop and implement an appropriate plan for the prevention and management of COVID-19 in the State's prisons and jails, as well as order other appropriate relief to ensure that infection does not spread unabated to inmates, correctional staff, and others in WVDCR custody. Plaintiffs ask that the Court expedite the deadline for responsive briefing, if any, from Defendants, and that the Court set this matter for a telephonic hearing as soon as practicable.

Factual Background

"On March 11, 2020, the World Health Organization announced that the COVID-19 outbreak can be characterized as a pandemic, as the rates of infection continue to rise in many locations around the world and across the United States." *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/. On March 13, President Trump declared a national emergency, noting that "[t]he spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems." *Id.* That same day, West Virginia Governor Jim Justice announced a statewide school closure plan as part of an "effort to protect all the people of West Virginia[.]" *See* "COVID-19 UPDATE," available at https://governor.wv.gov/News/press-releases/2020/Pages/COVID-19-UPDATE-Gov.-Justice,-Department-of-Education-issue-updated-guidance-on-school-closures-in-West-Virginia.aspx. Three days later, on March 16, Governor Justice declared a statewide state of emergency, under W. Va. Code § 15-5-2. *See* "A Proclamation," available at https://governor.wv.gov/Documents/2020%20Proclamations/State-of-Emergency-March-16-2020.pdf. In his declaration, Governor Justice noted that "it is of the utmost importance that [state officials] throughout the state have the ability to take measures necessary to ensure the safety of our citizens" during this epidemic which "constitutes a disaster under section two, article five, chapter fifteen of the Code of West Virginia" and which "has been deemed a pandemic by the World Health Organization[.]" *Id.* The same day, he announced that "correctional facilities . . . have halted all non-attorney visitation[.]" *See* "Gov. Justice Administration members, State officials provide updates on COVID-19 preparedness efforts," available at https://governor.wv.gov/News/press-releases/2020/Pages/Gov.-Justice-

Administration-members,-State-officials-provide-updates-on-COVID-19-preparedness-efforts.aspx. On March 22, 2020, the West Virginia Supreme Court of Appeals closed the West Virginia courts to all non-emergency business. *See Administrative Order*, available at http://www.courtswv.gov/covid19/JudicialEmergencyDeclared3-22-20.pdf. On March 23, 2020, Governor Justice issued an executive order directing that all West Virginia residents stay at home, other than in exceptional circumstances, to limit the transmission of the disease. *See Executive Order No. 9-20*, available at https://governor.wv.gov/Documents/2020%20Executive%20Orders/STAY-AT-HOME-ORDER-MARCH-23-2020.pdf.

It is well recognized that the virus is likely to spread extremely quickly in incarcerated settings, especially where—as here—the setting is substantially overcrowded such that appropriate social distancing is not an option. *See Charleston Gazette*, "Seven out of 10 WV jails were over capacity Wednesday while the House passed a bill meant to cut jail population," available at https://www.wvgazettemail.com/news/legislative_session/seven-out-of-wv-jails-were-over-capacity-wednesday-while/article_20a9e35d-3282-55b1-a01c-5f8eba73381a.html. Indeed, hundreds of inmates are currently incarcerated in West Virginia jails beyond the jails' established bedding capacity. This has required Defendants to house multiple inmates in cells that were intended for fewer people, such that there is simply no ability to maintain an appropriate six foot distance between individuals to prevent the spread of infection.

Moreover, Plaintiffs in this matter are medically vulnerable, rendering them at high risk for severe complications or death from COVID-19. For instance, Plaintiff Baxley suffers from severe asthma, among other disorders. According to the Center for Disease Control, he may therefore "be at a higher risk of getting very sick from COVID-19." *See Center for Disease Control and Prevention*, "Are you at higher risk for severe illness?—Asthma," available at

https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/asthma.html. Plaintiff Wells-Wright suffers from Chronic Obstructive Pulmonary Disease and emphysema, among other things. These conditions put her at a higher risk of severe outcomes if she contracts COVID-19. *See Pulmonary Advisor*, "COVID-19 Preparation Recommendations from the COPD Foundation," available at https://www.pulmonologyadvisor.com/home/topics/lung-infection/copd-foundation-issues-advice-for-patients-concerned-about-coronavirus/. Plaintiff Edmondson is 75 years old and suffers from a chronic sinus condition. He is likely therefore to suffer severe consequences if he contracts COVID-19. *See Center for Disease Control and Prevention*, "Are you at a higher risk for severe illness?—Older Adults," available at https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications/older-adults.html. Plaintiff Hall suffers from tachycardia, among other things, making him especially susceptible to a severe case of COVID-19. *See Harvard Health Publishing*, "Coronavirus Resource Center," available at https://www.health.harvard.edu/diseases-and-conditions/coronavirus-resource-center. Plaintiff Watson has Chronic Obstructive Pulmonary Disease and diabetes, among other things, placing him at higher risk for a severe case of COVID-19. *See id.* Plaintiff Reed suffers from diabetes and a heart condition, among other things, putting her at higher risk for a severe case of COVID-19. *See id.* And class member R.H. is HIV positive, putting him at risk of severe complications or death from COVID-19. *See id.*

As alleged in the First Amended Complaint, Defendants have persistently displayed deliberate indifference to the health, safety, and other basic needs of Plaintiffs. Even without demonstrated deliberate indifference to medical needs, incarceration in a jail or prison poses heightened health risks for inmates and correctional staff during this global pandemic. (*See* Declaration of Dr. Craig W. Haney, PHD, at 3-10, attached.) "The COVID-19 Pandemic presents penal institutions with an enormous challenge that they are ill-equipped to handle." (*Id.*

at 4.) Correctional facilities have little ability to implement the social distancing required to combat the spread of COVID-19 and are likely to resort to solitary confinement. (*See id.*) But "solitary confinement inflicts an additional set of very serious harmful effects that significantly undermine mental and physical health." (*See id.* at 5.) And "the Pandemic [itself] has traumatic psychological as well as physical consequences." (*See id.* at 9.) Respected health and correctional officials throughout the country have expressed grave concern about the risks to inmates, and have recommended release of inmates to ensure inmate health and safety as well as other immediate protective measures. (*See, e.g.*, Decs. of Drs. Beyrer, Meyer, Golob, Stern, Greifinger & Haney, attached hereto.)

In light of these circumstances, prisons and jails throughout the country have begun releasing thousands of inmates in an effort to prevent an outbreak of COVID-19 in crowded jails and prisons. *See The Wall Street Journal*, "Jails Release Prisoners, Fearing Coronavirus Outbreak," available at https://www.wsj.com/articles/jails-release-prisoners-fearing-coronavirus-outbreak-11584885600. "[A]t least 15 states—including Texas, New York, California and Ohio—have taken to releasing low-level offenders as well as those in the elderly and sick categories and thus considered most vulnerable to being rendered in a critical condition if they contract the unique pathogen." *See Fox News*, "Concern grows for vulnerable prison populations and employees as coronavirus spreads through overstuffed facilities," available at https://www.foxnews.com/us/concerns-grow-for-vulnerable-prison-population-and-the-safety-of-employees-as-coronavirus-spreads-into-overstuffed-cells; *see also Prison Policy Initiative*, "Responses to the COVID-19 pandemic," available at https://www.prisonpolicy.org/virusresponse.html (collecting sources). Iowa, for example, has started to expedite release of 700 inmates who have already granted parole. *See Times Republic*, "Iowa's prisons will accelerate release of approved inmates to mitigate COVID-19," available at

https://www.timesrepublican.com/news/todays-news/2020/03/iowas-prisons-will-accelerate-release-of-approved-inmates-to-mitigate-covid-19/. New Jersey has plans to "release as many as 1,000 people from its jails" based on an order signed by New Jersey's Chief Justice "authorizing the release of inmates serving certain types of sentences in county jails[.]" *See New York Times*, "1,000 Inmates Will Be Released from N.J. Jails to Curb Coronavirus Risk," available at https://www.nytimes.com/2020/03/23/nyregion/coronavirus-nj-inmates-release.html?auth=login-email&login=email.

Plaintiffs have requested from Defendants any plan that they have developed for managing the COVID-19 crisis, but Defendants have failed and refused to provide any such plan. No plan has been publicized by the Governor's Office or the WVDCR. The American Civil Liberties Union of West Virginia emailed a letter to the Division of Corrections and Rehabilitation on March 10, 2020, requesting information about any official plans the Division has for dealing with COVID-19. (*See* Ltrs. from ACLU to DCR, attached hereto.) Defendants responded on March 20, 2020, stating that DCR's plan is exempt from disclosure to the public under section 29B-1-4(19) of the West Virginia Code, but also attaching a letter that purports to outline the WVDCR's COVID-19 response plan, with sensitive security information removed. (*See* Ltr. from DCR to ACLU, attached hereto.) That letter provides little detail and fails to address most of the concerns of Plaintiffs outlined below. Likewise, Plaintiffs' counsel has requested such a plan from Defendants, which would be responsive to Plaintiffs' discovery requests in this matter and Defendants' ongoing responsibility to supplement their responses. (*See* Pl.'s 2d Set of Req,s for Prod. of Docs. to Defendants No. 11 ("Please produce copies of all policies, operating procedures, protocols, and/or directives governing the provision of medical and/or mental health care, including diagnosis and treatment, which have been in effect at any West Virginia Regional Jail facility since January 1, 2019.").) Defendants responded solely by

providing the WVDCR policy from 2016 regarding management of infectious diseases, but provided no additional information or documents related to efforts to address the current pandemic.

Defendants' lack of a transparent and comprehensive plan is alarming for its implications not just for inmates, but also for correctional staff and the community as a whole. Plaintiffs and all other people in the custody of West Virginia's Division of Corrections and Rehabilitation are highly vulnerable to outbreaks of contagious illnesses, and the risk is only heightened by the overcrowded and often unsanitary conditions in the prisons and jails, coupled with the already inadequate medical staffing and treatment across correctional facilities in the state. When COVID-19 enters West Virginia's correctional facilities, Plaintiffs in this case and others like them will suffer unnecessary pain and death. Failure to address COVID-19 in the state's correctional facilities also threatens the community at large, as hundreds of correctional, health care, and other staff interact with the incarcerated population every day, and then return to their homes and communities. Likewise, an outbreak within a jail or prison facility could quickly lead to overwhelming area hospitals with inmates who require ventilators or other significant medical interventions. Finally, many inmates only stay in jail for a few days—just long enough to contract COVID-19 and take it back to their communities when they are released, while not yet displaying any symptoms.

Further, West Virginia's correctional facilities are already significantly understaffed both in terms of custody staff and health care staff. *See WV News*, "Overcrowding, understaffing, inmate deaths continue to plague WV jails," available at https://www.wvnews.com/news/wvnews/overcrowding-understaffing-inmate-deaths-continue-to-plague-wv-jails/article_9a788e06-8f50-5907-bd53-40560a2d5f6f.html; *WV News*, "WV House bill would require PR bonds for misdemeanor offenses," available at

https://www.wvnews.com/news/wvnews/wv-house-bill-would-require-pr-bonds-for-misdemeanor-offenses/article_0a928d58-0275-5fda-9165-6353af6c4d26.html. As the result, staffing shortages created by infection and illness of staff need to be planned for and addressed.

To prevent the worst from happening, Plaintiffs request that this Court order that Defendants create, implement, and disclose an appropriate evidence-based, substantive, and detailed plan that can help prevent a COVID-19 outbreak, minimize its impact if an outbreak does occur, and contribute to broader efforts in the state and the country to "flatten the curve" of the outbreak. Plaintiffs request that such a plan include (but not be limited to):

- Inmate education;
- Staff education;
- Requiring staff who experience any COVID-19 symptoms to stay home until tested, or for a mandatory fourteen days;
- Health care and custody staffing plans for keeping the facilities running safely as staff stays home sick or quarantined;
- Staffing plans for services provided by inmates themselves as inmates get sick;
- Screening, testing, treatment, and housing of plaintiffs and similarly situated individuals;
- Plans for additional precautions to prevent the exposure of vulnerable populations within the facilities to the virus;
- Housing of inmates exposed to the virus;
- Provision of hygiene and cleaning supplies to all inmates;
- Enhanced plans for cleaning shared spaces and items (such as phones) in between each inmate's use;
- Coordination with community hospitals and among the correctional facilities in the state; and

- Plans for removal of charges for telephone calls or other methods of communication and psychological support for inmates while visitation is eliminated.

Plaintiffs further request that the Court issue an order requiring that sufficient inmates be released from custody to enable DCR to maintain safe distances between inmates to prevent the spread of COVID-19 and to permit appropriate quarantine and treatment of inmates in custody who ultimately contract the virus.

Argument

"The traditional office of a preliminary injunction is to protect the status quo and to prevent irreparable harm during the pendency of a lawsuit ultimately to preserve the court's ability to render a meaningful judgment on the merits." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003). "Mandatory preliminary injunctions generally do not preserve the status quo and normally should be granted only in those circumstances when the exigencies of the situation demand such relief." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d at 526 (alterations omitted).

In deciding whether to grant a preliminary injunction, "court[s] should consider (1) the likelihood of irreparable harm to the plaintiff if the preliminary injunction is denied; (2) the likelihood of harm to the defendant if the injunction is granted; (3) the likelihood that the plaintiff will succeed on the merits; and (4) the public interest." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 526 (4th Cir. 2003). "In applying this four-factor test, the irreparable harm to the plaintiff and the harm to the defendant are the two most important factors." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 526 (4th Cir. 2003) (alterations omitted). "Emphasis on the balance of these first two factors results in a sliding scale that demands less of a showing of likelihood of success on the merits when the balance of hardships weighs strongly in favor of the plaintiff, and vice versa." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 526 (4th Cir.

2003).

As outlined above, this global pandemic is exactly the kind of extraordinary circumstance that warrants mandatory injunctive relief because of the grave risk of serious illness and death to Plaintiffs and others similarly situated due to their conditions of confinement in WVDCR custody. And it is that same grave risk that means that the likelihood of irreparable harm to Plaintiffs here and others similarly situated, is unacceptably high. Conversely, Defendants will suffer no harm if the injunction is granted. Developing a plan to prevent the spread of COVID-19 in West Virginia's DCR facilities protects not only the inmate population, but all WVDCR employees, their families, and the community at large. Ultimately, an appropriate plan will reduce spread of the virus, death, and overwhelming the already limited correctional and community health care systems. It is in the best interest of Plaintiffs, Defendants, and the public for Defendants to establish a rigorous plan for dealing with COVID-19 and for the correctional institutions to maintain a limited population during this crisis. Therefore, factors one, two, and four of the preliminary injunction analysis all weigh heavily in favor of granting the requested relief.

With respect to the third factor, the likelihood of success on the merits, failing to develop contingencies to address the extremely likely event of COVID-19 outbreaks in one or more of the West Virginia jail facilities would violate the constitutional rights of Plaintiffs and others inmates housed in jail facilities. As the Supreme Court has explained, an inmate's constitutional rights are violated by conditions that pose an unreasonable *risk* of future harm, even if that harm has not yet come to pass.

> That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is "reasonable safety." *DeShaney, supra,* 489 U.S., at 200, 109 S. Ct., at 1005. . . . It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.

Helling v. McKinney, 509 U.S. 25, 33-34 (1993). The Court in *Helling* specifically recognized that communicable disease could constitute such an "unsafe, life-threatening condition:"

> In *Hutto v. Finney*, 437 U.S. 678, 682, 98 S.Ct. 2565, 2569, 57 L.Ed 2d 522 (1978) we noted that inmates in punitive isolation were crowded into cells and that some of them had infectious maladies such as hepatitis and venereal disease. This was one of the prison conditions for which the Eighth Amendment required a remedy, even though it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed. . . . *Nor can we hold that prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms*.

Helling, 509 U.S. at 33 (emphasis added); *see also id.* at 34 (citing with approval *Gates v. Collier*, 501 F.2d 1291 (5th Cir. 1974), which held that prisoners were entitled to relief under the Eighth Amendment when they showed, *inter alia*, "the mingling of inmates with serious contagious diseases with other prison inmates").

COVID-19 has the potential to cause significant and life-threatening illness to inmates as well as barriers to medical care and to Defendants' ability to comply with the constitutional requirements for inmate care during incarceration. West Virginia's state-run correctional facilities are already significantly understaffed both in terms of custody staff and health care staff. Should staff be exposed either in the correctional facilities or in the community and show symptoms, they must be quarantined and/or treated, further reducing available staff to provide medical care or to facilitate such care by, for example, providing security and transportation services. Defendants' ability to rely on agency and as-needed medical staff may decrease as community demand for those services increases. For the same reason, the availability of community healthcare services, including for hospitalization and specialty appointments, may be substantially curtailed. When COVID-19 arrives in the prison system, demands on healthcare services generally—including medical and custody staff—will only increase as more patients require screening, isolation, testing, and clinical management.

Conclusion and Prayer for Relief

There is a real and immediate risk that potential class members and named plaintiffs incarcerated in West Virginia jails will die or suffer serious medical injuries if Defendants' fail to properly prepare for the COVID-19 pandemic. The Division of Corrections and Rehabilitation and its health care contractors have put forth no plan demonstrating their ability to address the tsunami that is likely already in the community and may soon crash through the prison gates (if it is not there already), swamping the Division and its contractors' ability to respond and protect the lives of those in its custody. All four factors for analyzing a request for preliminary injunction favor granting one here.

The Court should therefore order Defendants to develop, disclose, and implement a plan that undertakes all appropriate actions to protect Plaintiffs and others who are similarly situated. In particular, the Court should order Defendants to consult with correctional healthcare experts to immediately develop and implement a plan for the prevention and management of COVID-19 in the State's correctional facilities. Specifically, the plan should include the following components:

1. Inmate education;
2. Staff education;
3. Requiring staff who experience any COVID-19 symptoms to stay home until tested, or for a mandatory fourteen days;
4. Health care and custody staffing plans for keeping the facilities running safely as staff stays home sick or quarantined;
5. Staffing plans for services provided by inmates themselves as inmates get sick;
6. Screening, testing, treatment, and housing of plaintiffs and potential class members;
7. Plans for additional precautions to prevent the exposure of vulnerable populations within the facilities to the virus;

8. Housing of inmates exposed to the virus;
9. Provision of hygiene and cleaning supplies to all inmates;
10. Enhanced plans for cleaning shared spaces and items (such as phones) in between each inmate's use; and
11. Coordination with community hospitals and among the correctional facilities in the state; and
12. Elimination of charges for telephone calls and other methods of contact between inmates and their loved ones.

Plaintiffs ask that the Court order Defendants to immediately file this plan with the Court.

Finally, Plaintiffs respectfully request that this Court immediately issue an order directing WVDCR to release a sufficient number of inmates reduce overcrowding and allow for appropriate social distancing within the jails and prisons to protect medically vulnerable inmates as well as those who remain incarcerated and correctional staff.

As Courts and public officials around the country have recognized, lives are at immediate risk without appropriate meaningful action. As a result, Plaintiffs respectfully request that the Court grant the above relief, and such other relief as the Court deems equitable and just.

JOHN BAXLEY, JR., et. al., on behalf of themselves and other similarly situated inmates,

By Counsel:

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Declaration for Persons in Detention and Detention Staff
COVID-19

Chris Beyrer, MD, MPH
Professor of Epidemiology
Johns Hopkins Bloomberg School of Public Health
Baltimore, MD

I, Chris Beyrer, declare as follows:

1. I am a professor of Epidemiology, International Health, and Medicine at the Johns Hopkins Bloomberg School of Public Health, where I regularly teach courses in the epidemiology of infectious diseases. This coming semester, I am teaching a course on emerging infections. I am a member of the National Academy of Medicine, a former President of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. I have been active in infectious diseases Epidemiology since completing my training in Preventive Medicine and Public Health at Johns Hopkins in 1992.
2. I am currently actively at work on the COVID-19 pandemic in the United States. Among other activities I am the Director of the Center for Public Health and Human Rights at Johns Hopkins, which is active in disease prevention and health promotion among vulnerable populations, including prisoners and detainees, in the US, Africa, Asia, and Latin America.

The nature of COVID-19

3. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the WHO. Cases first began appearing sometime between December 1, 2019 and December 31, 2019 in Hubei Province, China. Most of these cases were associated with a wet seafood market in Wuhan City.
4. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
5. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.3 to 3.5%, which is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.
6. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate is higher in men, and varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardio-vascular disease, respiratory disease, diabetes, and immune compromise.
7. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS) which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical

ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and parts of China.

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 100 countries and all continents, heavily affected countries include Italy, Spain, Iran, South Korea, and increasingly, the US. As of today, March 16th, 2020, there have been 178,508 confirmed human cases globally, 7,055 known deaths, and some 78,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.

9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.

12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase community rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.

13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.

14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities.

15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff.

16. In addition to the nature of the prison environment, prison and jail populations are also at additional risk, due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death.
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.
18. Pre-trial detention should be considered only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, should be prioritized for release. Immigrants awaiting decisions on their removal cases who are not a flight risk can be monitored in the community and should be released from immigration detention centers. Older inmates and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) should be considered for release.
19. Given the experience in China as well as the literature on infectious diseases in jail, an outbreak of COVID-19 among the U.S. jail and prison population is likely. Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole.

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

Executed this 16th day of March, 2020.

Professor Chris Beyrer[1]

[1] These views are mine alone; I do not speak for Johns Hopkins University or any department therein.

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Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 132,000 people have been diagnosed with COVID-19 around the world and 4,947 have died.[2] In the United States, about 1,700 people have been diagnosed and 41 people have died thus far.[3] These numbers are likely an underestimate, due to the lack of availability of testing.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

5. People in the high-risk category for COVID-19, i.e., the elderly or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

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[1] Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. Journal of Correctional Health Care OnlineFirst, published on May 12, 2010 as doi:10.1177/1078345810367593.

[2] See https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd, accessed March 13, 2020.

[3] See https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1, accessed March 13, 2020.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.

7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. At least one nursing home in the Seattle area has had cases of COVID-19 and has been quarantined.

9. The Seattle metropolitan area, hit hard by COVID, is the epicenter of the largest national outbreak at this time. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the immigration detention facility in Tacoma, Washington. Immigration courts and the ICE field office in Seattle have already closed this month due to staff exposure to COVID-19.

10. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

11. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

12. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

13. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks

to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

14. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.

15. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from NWDC by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with the Pierce County or Washington State Department of Health.

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

Executed this *14th* day in March, 2020 in New York City, New York.

Robert B. Greifinger, M.D.

Declaration of Dr. Marc Stern

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I also have considerable familiarity with the immigration detention system. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I have also served as a consultant to Human Rights Watch in their preparation of two reports on health-related conditions of confinement in ICE detention facilities. In those capacities, I have visited and examined more than 20 ICE detention facilities and reviewed hundreds of records, including medical records and detention death reviews of individuals in ICE detention. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease and has reached pandemic status. At least 132,758 people around the world have received confirmed diagnoses of COVID 19 as of March 13, 2020, including 1,629 people in the United States. At least 4,955 people have died globally as a result of COVID-19 as of March 13, 2020, including 41 in the United States. These numbers will increase, perhaps exponentially.

3. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. The only way to control the virus is to use preventive strategies, including social distancing.

4. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that.

5. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

6. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.

7. Detention facilities are congregate environments, i.e. places where people live and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. This therefore presents an increased danger for the spread of COVID-

19 if and when it is introduced into the facility. To the extent that detainees are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, the risks of spread are greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in another congregate environment: nursing homes and cruise ships.

8. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in detention facilities, placing people at risk, especially when the number of detainees is high.

9. For detainees who are at high risk of serious illness or death should they contract the COVID-19 virus, release from detention is a critically important way to meaningfully mitigate that risk. Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff such that they can continue to ensure the safety of detainees.

10. The release of detainees, especially those with increased health-related vulnerability, also supports the broader community because carceral and detention settings, regardless of the level of government authorities that oversee them, are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a Federal immigration detention center slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.

11. As a correctional public health expert, I recommend release of eligible individuals from detention, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19.

12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the detention center, either among staff or detainees. In the event of this occurring, and eligible detainees being quarantined or isolated due to possible exposure to the virus, I recommend that the detainee(s) be tested for the virus if testing is available. Armed with the results of that test if it is available, or in the absence of other instructions from the health authority of the municipality to which they will be returning or the Washington State public health authority, those who can easily return to a home without exposure to the public, should be released to that home for continued quarantine or isolation for the appropriate time period. All others can be released to appropriate housing as directed or arranged in coordination with the relevant health authority.

13. I have reviewed Plaintiffs' complaint and on the basis of the claims presented, conclude that Plaintiffs have underlying medical conditions that increase the risk of serious illness or death if exposed to COVID-19. Due to the risks caused by the congregate environment in immigration

detention, compounded by the marked increase in risk conferred by their underlying medical conditions, I recommend their release.

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

Executed this __15th___ day in March, 2020 in Tumwater, Washington.

Dr. Marc Stern

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.

4. Chen NE, **Meyer JP**, Avery AK, Draine J, Flanigan TP, Lincoln T, Spaulding AC, Springer SA, Altice FL. Adherence to HIV treatment and care among previously homeless jail detainees. AIDS And Behavior 2013, 17:2654-66.
5. Althoff AL, Zelenev A, **Meyer JP**, Fu J, Brown SE, Vagenas P, Avery AK, Cruzado-Quiñones J, Spaulding AC, Altice FL. Correlates of retention in HIV care after release from jail: results from a multi-site study. AIDS And Behavior 2013, 17 Suppl 2:S156-70.
6. Williams CT, Kim S, **Meyer J**, Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. AIDS And Behavior 2013, 17 Suppl 2:S195-202.
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.
9. **Meyer JP**, Cepeda J, Springer SA, Wu J, Trestman RL, Altice FL. HIV in people reincarcerated in Connecticut prisons and jails: an observational cohort study. The Lancet. HIV 2014, 1:e77-e84.
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.
14. Shrestha R, Karki P, Altice FL, Huedo-Medina TB, **Meyer JP**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and anticipation of practicing safer drug- and sex-related behaviors among high-risk drug users on methadone treatment. Drug And Alcohol Dependence 2017, 173:107-116.
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.
17. Hoff E, Marcus R, Bojko MJ, Makarenko I, Mazhnaya A, Altice FL, **Meyer JP**. The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. Journal Of Substance Abuse Treatment 2017, 83:36-44.

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.
19. Peasant C, Sullivan TP, Ritchwood TD, Parra GR, Weiss NH, **Meyer JP**, Murphy JG. Words can hurt: The effects of physical and psychological partner violence on condom negotiation and condom use among young women. Women & Health 2018, 58:483-497.
20. Loeliger KB, Altice FL, Desai MM, Ciarleglio MM, Gallagher C, **Meyer JP**. Predictors of linkage to HIV care and viral suppression after release from jails and prisons: a retrospective cohort study. The Lancet. HIV 2018, 5:e96-e106.
21. Odio CD, Carroll M, Glass S, Bauman A, Taxman FS, **Meyer JP**. Evaluating concurrent validity of criminal justice and clinical assessments among women on probation. Health & Justice 2018, 6:7.
22. Loeliger KB, Altice FL, Ciarleglio MM, Rich KM, Chandra DK, Gallagher C, Desai MM, **Meyer JP**. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. The Lancet. HIV 2018, 5:e617-e628.
23. Loeliger KB, **Meyer JP**, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. PLoS Medicine 2018, 15:e1002667.
24. Azbel L, Wegman MP, Polonsky M, Bachireddy C, **Meyer J**, Shumskaya N, Kurmanalieva A, Dvoryak S, Altice FL. Drug injection within prison in Kyrgyzstan: elevated HIV risk and implications for scaling up opioid agonist treatments. International Journal Of Prisoner Health 2018, 14:175-187.
25. Peasant C, Montanaro EA, Kershaw TS, Parra GR, Weiss NH, **Meyer JP**, Murphy JG, Ritchwood TD, Sullivan TP. An event-level examination of successful condom negotiation strategies among young women. Journal Of Health Psychology 2019, 24:898-908.
26. Ranjit YS, Azbel L, Krishnan A, Altice FL, **Meyer JP**. Evaluation of HIV risk and outcomes in a nationally representative sample of incarcerated women in Azerbaijan, Kyrgyzstan, and Ukraine. AIDS Care 2019, 31:793-797.
27. Rhodes T, Azbel L, Lancaster K, **Meyer J**. The becoming-methadone-body: on the onto-politics of health intervention translations. Sociology Of Health & Illness 2019, 41:1618-1636.
28. Olson B, Vincent W, **Meyer JP**, Kershaw T, Sikkema KJ, Heckman TG, Hansen NB. Depressive symptoms, physical symptoms, and health-related quality of life among older adults with HIV. Quality Of Life Research : An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation 2019.

Chapters, Books, and Reviews

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.
30. **Meyer JP**, Springer SA, Altice FL. Substance abuse, violence, and HIV in women: a literature review of the syndemic. Journal Of Women's Health (2002) 2011, 20:991-1006.
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.
37. **Meyer JP**, Moghimi Y, Marcus R, Lim JK, Litwin AH, Altice FL. Evidence-based interventions to enhance assessment, treatment, and adherence in the chronic Hepatitis C care continuum. The International Journal On Drug Policy 2015, 26:922-35.
38. Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J**. Infectious Diseases in Underserved Populations. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. Current Diagnosis and Treatment- Infectious Diseases. McGraw-Hill Medical 2016.
39. **Meyer JP**, Womack JA, Gibson B. Beyond the Pap Smear: Gender-responsive HIV Care for Women. The Yale Journal Of Biology And Medicine 2016, 89:193-203.
40. **Meyer JP**, Muthulingam D, El-Bassel N, Altice FL. Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions. AIDS And Behavior 2017, 21:3527-3548.
41. Shrestha R, McCoy-Redd B, **Meyer J**. Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. The Opioid Epidemic and Infectious Diseases. Elsevier 2019.
42. **Meyer JP**, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. Drug And Alcohol Dependence 2019, 197:158-163.

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.
46. Brinkley-Rubinstein L, Dauria E, Tolou-Shams M, Christopoulos K, Chan PA, Beckwith CG, Parker S, **Meyer J**. The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems. Current HIV/AIDS Reports 2018, 15:93-95.
47. **Meyer JP**. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. Journal Of Women's Health (2002) 2019, 28:1017-1018.

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.
50. Vazquez Guillamet LJ, Malinis MF, **Meyer JP**. Emerging role of Actinomyces meyeri in brain abscesses: A case report and literature review. IDCases 2017, 10:26-29.
51. Harada K, Heaton H, Chen J, Vazquez M, **Meyer J**. Zoster vaccine-associated primary varicella infection in an immunocompetent host. BMJ Case Reports 2017, 2017.
52. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Answer to December 2017 Photo Quiz. Journal Of Clinical Microbiology 2017, 55:3568.
53. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Photo Quiz: Peripheral Blood Smear in a Ugandan Refugee. Journal Of Clinical Microbiology 2017, 55:3313-3314.

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

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

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

2. COVID-19 is a novel zoonotic coronavirus that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of March 12, 2020, there are over 140,000 confirmed cases of COVID-19. COVID-19 has caused over 5,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.

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

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

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

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

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

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

9. COVID-19 is known to be spreading in the Seattle, Washington-area community. As of March 11, 2020 there are 270 confirmed cases of COVID-19 (an increase of 36 from March 10, 2020) and twenty-seven deaths from COVID-19 in the Seattle area. This

represents the largest known outbreak in the United States, and one the largest known outbreaks in the world as of March 12, 2020.

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

11. Based on the recovered genomes of the virus from the community analyzed by the Nextstrain project run by Dr. Trevor Bedford of the Fred Hutchinson Cancer Research Center in Seattle, it is known that the infection is being shared from person to person in and around Seattle. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. The strain of virus spreading in the Seattle area is genetically related to the strain of virus that spread readily on the cruise ships.

12. The COVID-19 outbreak in Seattle has resulted in the need for unprecedented public health measures, including multiple efforts to facilitate and enforce social distancing. These include encouraging employees to work from home, bans of gathering of more than 250 people, closure of schools, closure of the University of Washington campus in Seattle, limitations of visitation to skilled nursing facilities, and cancellation of major public events. Individuals have been asked to delay or cancel health care procedures in order to free up capacity within the system.

13. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers, particularly when residents cannot engage in proper hygiene and isolate themselves from infected residents or staff.

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

such as an immigration detention center, with limited access to adequate hygiene facilities and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 13th day in March, 2020 in Ann Arbor, Michigan.

Dr. Jonathan Louis Golob

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March 10, 2020

Commissioner Betsy Jividen
Sent via email to betsy.jividen@wv.gov

Re: COVID-19 Plans

Dear Commissioner Jividen:

I am writing to request copies of any plans the Division of Corrections and Rehabilitation has put in place to protect incarcerated individuals in the facilities under the Division's control from COVID-19. In the event no plans have formally been put in place, our organization urges you to immediately develop evidence-based and proactive plans for the prevention and management of COVID-19. We would like to meet with you ASAP to discuss how you are protecting the health of the people in your custody and the people who work in jails and prisons.

As you know, those that are incarcerated are highly vulnerable to outbreaks of contagious illnesses. They are housed in close quarters and are often in poor health. Without the active engagement of the administration, they have little ability to inform themselves about preventive measures, or to take such measures if they do manage to learn of them.

This is an urgent matter. Having an appropriate, evidence-based plan in place can help prevent an outbreak and minimize its impact if one does occur. Not having one may cost lives.

Some of the critical issues that must be addressed are:

- **Education of the people in your custody:** Those that are incarcerated need to be informed about the virus and the measures they can take to minimize their risk of contracting or spreading the virus. They must be educated on the importance of proper handwashing, coughing into their elbows, and social distancing to the extent they can. Information about the spread of the virus, the risks associated with it, and prevention and treatment measures must be based on the best available science.

- **Education of the staff:** Correctional, administrative, and medical staff all must be educated about the virus to protect themselves and their families, as well as the people in their custody.

- **Staffing plans:** Regardless of how many staff stay home because they are sick, prisons and jails will have to continue functioning. There must be a plan for how necessary functions and services will continue if large numbers of staff are out with the virus.

- **Staffing plans for services provided by those incarcerated:** Many tasks, such as food preparation and basic sanitation, are performed by incarcerated individuals. The plans for an outbreak must also address how necessary tasks performed by those individuals will continue if large numbers of the incarcerated population are ill.

- **Provision of hygiene supplies:** The most basic aspect of infection control is hygiene. There must be ready access to warm water and adequate hygiene supplies, both for handwashing and for cleaning.

- **Screening and testing of the people in your custody:** The plan must include guidance, based on the best science available, on how and when to screen and test people in your facilities for the virus.

- **Housing of persons exposed to the virus:** The plan must describe how and where people in the system will be housed if they are exposed to the virus, are at high risk of serious illness if they become infected, or become sick with it. *This should not result in prolonged, widespread lock-downs.* Any lock-downs or interruptions in regular activities, such as exercise or visits and phone calls with families or attorneys, should be based solely on the best science available and should be as limited as possible in scope and duration.

- **Treatment:** Courses of treatment must be evidence-based, available immediately, and in compliance with scientifically-based public health protocols.

- **Vulnerable Populations:** The plan must provide for additional precautions for those who are at high risk of serious illness if they are infected, such as pregnant women and people with chronic illnesses, compromised immune systems, or disabilities, and people whose housing placements restrict their access to medical care and limit the staff's ability to observe them.

- **Data collection:** The collection of data regarding COVID-19 will be part of the public health response. As with any contagious disease, data collection is critical to understanding and fighting the virus. The system must be part of this process. The same information that is tracked in the community must be tracked in our jails and prisons.

Please let us know when you will be available to discuss your plans.

Sincerely,

Loree Stark
Legal Director
ACLU-WV

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March 19, 2020

Commissioner Betsy Jividen
Sent via email to betsy.jividen@wv.gov

Re: Request for COVID-19 Plans

Commissioner Jividen,

I am writing to follow up on the March 10, 2020 letter I sent requesting copies of any plans ODCR has in place to protect incarcerated individuals in the facilities under the Division's Control from COVID-19. That includes, but is not limited to, plans relating to protecting the health of the incarcerated as well as any policies surrounding visitation restrictions and communication via phone, email, etc.

To date, I have not received an acknowledgment of receipt of the letter, responsive documents, or a denial.

West Virginia Code Section 29B-1-3 requires agencies to respond to requests for public records within **five business days**. Please provide the responsive documents by **12 p.m. March 20, 2020**, or our organization will move forward to institute proceedings under Section 29B-1-3 for injunctive or declaratory relief in circuit court.

West Virginia's Freedom of Information Act is "liberally construed with the view of carrying out" a policy of disclosure, while exemptions are to be narrowly construed. W. Va. Code §29B-1-1. Any party claiming that an exemption applies bears the burden of proving its applicability. *See Daily Gazette v. W. Va. Dev. Office*, 482 S.E.2d 180, 187 (W. Va. 1996). Documents regarding policies of public agencies after the policies have been formulated are not subject to the "internal memoranda or letters" exemption to the WV-FOIA provisions. *See id.* at 192. Finally, for any undisclosed or redacted records, we request a *Vaughn* index.

Thank you in advance for your prompt response. Please furnish all records to lstark@acluwv.org. You can reach me on my cell at 914-393-4614 with any questions.

Regards,

Loree Stark
Legal Director, ACLU-WV

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JEFF S. SANDY CFE, CAMS
CABINET SECRETARY

THOMAS L. KIRK
DEPUTY SECRETARY

DRAFT

Date: **Friday, March 20, 2020**
To: **Loree Stark, ACLU**
From: **Secretary Jeff Sandy, CFE, CAMS**
Re: **COVID-19 and W.Va. correctional facilities**

As our fellow West Virginians and Americans continue to respond to COVID-19, be assured that our Division of Corrections and Rehabilitation and its prisons, jails and juvenile centers are committed to reducing risk and protecting the health and safety of our employees, populations, volunteers, contractors, and others who enter these facilities and do business with us.

DMAPS and DCR have taken numerous steps that represent our best judgment at the present time, informed by the U.S. Centers for Disease Control and Prevention, our own Department of Health and Human Resources, and other recognized authorities.

We have provided ample and continuing information, guidelines and expectations to all of our facility superintendents that address in considerable detail:

- employee and inmate education regarding COVID-19
- continued attention to proper hygiene and sanitation practices
- increased emphasis on **frequent** cleaning and disinfection of high-touch areas
- screening protocols for inmates, employees, and contractors
- transportation and movement procedures
- practices for sick employees
- quarantine and isolation options.

To limit the flow of traffic in and out of our facilities, are working with the courts to utilize video court appearances whenever possible. We have also asked that our volunteers and state Department of Education personnel not return to our facilities at this time.

In addition, a new and comprehensive DCR COVID-19 policy takes effect today (March 20) that supersedes prior directives. Included in the updated policy are protocols and requirements that address the continued use of CDC-standardized screening procedures for inmates, employees and contractors. Employees and others upon entry to DCR facilities and office buildings must now also have their temperatures taken.

We will continue to update and augment these policies and procedures whenever warranted. All told, we have provided our superintendents, other administrators and staff with the information and flexibility they need to make the best decisions for the health and safety of everyone in their facilities.

You have likely heard that in an effort to limit exposure from outside sources, non-attorney visitation at all facilities remains halted until further notice. Until that visitation can resume, use of electronic visitation and telephone calls continues. The vendors who provide DCR's phone, kiosk and tablet services have all have agreed to provide weekly allotments of free phone calls and video visit sessions. We have also front-loaded important information about COVID-19, appropriate personal hygiene practices and other topics on the tablets and with the kiosks. This information is the first thing the inmates see when they try to access these devices. Of course, inmates can continue to send and receive letters and other correspondence through the U.S. Mail.

Of course, our facility leaders and staff continue to work closely with their respective contracted medical services providers, which have the personnel and protocols in place for these and other infectious diseases. And under the new policy, inmate medical co-pays have been suspended.

As for our employees, we have canceled all out-of-state travel and have encouraged video conferencing in lieu of in-person meetings and gatherings. All of our facilities have a supply of the appropriate surgical masks, and Gov. Justice announced on Thursday that corrections will receive a portion of the 100,000 N95 masks procured by the state this week.

Please know that your support has been crucial to the success of this department and its Division of Corrections and Rehabilitation. I very much appreciate your inquiry, and agree that we must ensure that all West Virginia are kept from harm's way. I know that you and your fellow legislators will help us achieve that vital mission.

DRAFT