UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

United States of America, **v.** **Samuel H. Powell,** **Defendant.**	**Case No. 1:94-cr-00316 (ESH)**

UNOPPOSED EMERGENCY MOTION FOR COMPASSIONATE RELEASE

Samuel H. Powell, through counsel, respectfully requests that this Court order his compassionate release under 18 U.S.C. § 3582(c)(1)(A) because of the COVID-19 global pandemic. The United States, through Assistant United States Attorney Dineen Baker, is not opposed to the proposed order granting his request.[1]

Mr. Powell is 55-years-old, suffers from several respiratory problems (including sleep apnea and asthma), and has only 3 months remaining on his 262 month sentence.[2] He is set to be released on June 16, 2020. Currently, he is incarcerated at the Correctional Treatment Facility ("CTF") in DC. Just yesterday, on March 26, 2020, the DC Jail confirmed that an inmate inside of CTF—the exact facility where Mr. Powell is incarcerated—has tested positive

[1] The government kindly notified counsel that it had no opposition to Mr. Powell's request for release under 18 U.S.C § 3582(c)(1) before counsel had drafted the motion. Counsel has since provided the motion and proposed order to government to confirm its position, but as of the filing of this motion has not yet heard back.

[2] He was sentenced to 262 months for attempted bank robbery (count 1); using a firearm in furtherance of the attempted armed bank robbery (count 2); escaping from custody (count 3); and armed bank robbery (count 4). *See* Judgement, ECF No. 29.

for COVID-19. *See* Keith Alexander, *After D.C. jail confirms first inmate with covid-19, officials isolate 36 other inmates*, the Washington Post (Mar. 26, 2020).[3] This inmate has been jailed since July 29, 2019, and has not been to court since January 27, 2020. *Id.* Surely, when more tests are conducted, more positive cases will be uncovered.

On March 23, 2020, the parties jointly requested that the Court recommend to the Bureau of Prison that he be placed in home confinement to serve the remainder of his sentence. *See* ECF No. 93. The next day, on March 24, 2020, this Court granted the request and made the recommendation. *See* ECF No. 95. However, the BOP recently notified defense counsel that it will *not* follow this Court's recommendation. It stated that Mr. Powell is ineligible for community programs including home confinement because he has an open case, detainer or warrant.[4] As a consequence, Mr. Powell will remain incarcerated at CTF, where there is at least one known highly contagious carrier of COVID-19, to serve the last 3 months on his 262 month sentence. This is absurd.

Courts all over the country, in various procedural postures, are acknowledging the reality

[3] Available at https://www.washingtonpost.com/local/public-safety/after-dc-jail-confirms-first-inmate-with-covid-19-officials-isolate-36-other-inmates/2020/03/26/4610cd86-6f68-11ea-b148-e4ce3fbd85b5_story.html (last visited Mar. 27, 2020).

[4] Mr. Powell currently has an open case in the D.C. Superior Court (Case No. 2020-CMD-01702). The charge is for a misdemeanor offense. According to police reports, Mr. Powell allegedly assaulted a fellow inmate at the Half Way House in response to the "continuously harassing and . . . derogatory comments [the complainant made] towards [Mr. Powell's] friend who happens to be transgender and housed in the same location." *See* Ex. F at 2. At the detention hearing, *the Superior Court released him on personal recognizance*. *Id.* at 3-6. In addition, the prosecutor offered him a deferred sentencing agreement. Progress on the case has been postponed, however, because of the current pandemic. So Mr. Powell now finds himself in an impossible situation: The BOP says he is ineligible to be released from federal custody because he has an open case in D.C. Superior Court. The problem: his case in D.C. Superior Court will remain open throughout the pandemic *because* of the pandemic.

of the danger of COVID-19 in detention facilities and the uncontroverted evidence—provided in sworn statements by medical experts, *see* Exs. A-E—that it is safer for the entire community if inmates, like Mr. Powell, who are at high-risk of contracting the virus and who do not pose any immediate danger to others, are released from custody.[5] Judge Moss recently released a defendant charged with both gun and drug offenses from pretrial detention in light of the COVID-19 pandemic. *See* Min. Order, *United States v. Brent Jaffee*, No. 19-cr-88 (RDM) (D.D.C. Mar. 26, 2020). As he stated,

> [T]he Court is now convinced that incarcerating the defendant while the current COVID-19 crisis continues to expand poses a greater risk to community safety than posed by Defendant's release to home confinement. All responsible government agencies have advised of the risk of transmission posed by large gatherings, and the Court understands the defendant is housed in a unit with dozens other detained individuals. The risk of the spread of the virus in the jail is palpable, and the risk of overburdening the jail's healthcare resources, and the healthcare resources of the

[5] *See Xochihua-James v. Barr*, No. 18-71460 (9th Cir. Mar. 23, 2020) (unpublished) (*sua sponte* releasing detainee from immigration detention "in light of the rapidly escalating public health crisis"); *United States v Garlock*, 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020) (citing "chaos" inside federal prisons in *sua sponte* extending time to self-surrender: "[b]y now it almost goes without saying that we should not be adding to the prison population during the COVID-19 pandemic if it can be avoided"); *United States v. Perez*, 2020 WL 1329225, at *1 (S.D.N.Y. Mar. 19, 2020) (releasing defendant due to the "heightened risk of dangerous complications should he contract COVID-19"); *United States v. Stephens*, 2020 WL 1295155, __F. Supp. 3d__ (S.D.N.Y. Mar. 19, 2020) (releasing defendant in light of "the unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic"); *In re Manrigue*, 2020 WL 1307109 (N.D. Cal. Mar. 19, 2020) ("The risk that this vulnerable person will contract COVID-19 while in jail is a special circumstance that warrants bail."); *In re Request to Commute or Suspend County Jail Sentences*, Docket No. 084230 (N.J. Mar. 22, 2020) (releasing large class of defendants serving time in county jail "in light of the Public Health Emergency" caused by COVID-19); *see also United States v. Matthaei*, 2020 WL 1443227, at *1 (D. Idaho Mar. 16, 2020) (extending self-surrender date by 90 days in light of COVID-19); *United States v. Barkman*, 2020 U.S. Dist. LEXIS 45628 (D. Nev. Mar. 17, 2020) (suspending intermittent confinement because "[t]here is a pandemic that poses a direct risk if Mr. Barkman . . . is admitted to the inmate population of the Wahoe County Detention Facility"); *United States v. Copeland,* No. 2:05-cr-135-DCN (D.S.C. Mar. 24, 2020) (granting compassionate release to defendant in part due to "Congress's desire for courts to release individuals the age defendant is, with the ailments that defendant has during this current pandemic").

> surrounding community is real. On the other hand, if defendant is confined at home and has contact only with his wife, the risk to him (including his heightened risk due to the underlying health condition he disclosed to the Court) and to others will be significantly reduced).

Id.; *see also United States v. Harris*, No. 19-cr-356-RDM, ECF No. 36 (D.D.C. Mar. 27, 2020) ("[W]e do not know with any certainty whether Harris will contract the virus if he remains at the D.C. Jail, and if he does, we do not know whether he will suffer from any severe symptoms. But uncertainty is endemic in the present circumstances, and that uncertainty cannot preclude courts from acting until the damage has been done.").

In a similar vein, Attorney General William Barr recently directed the Bureau of Prisons "to increase the use of home confinement in a bid to stem the impact of the novel coronavirus on the system." *See* Matt Zapotosky, *Federal Bureau of Prisons will expand use of home confinement amid pandemic, attorney general says*, The Washington Post (Mar. 26, 2020)—attached as Ex. G.[6] In response, the BOP reported that it "was assessing its population to identify who had already served a substantial portion of their sentence, posed no threat and might have preexisting conditions that would make them particularly vulnerable." *Id.* Given that Mr. Powell arguably meets all of those criteria but nonetheless remains incarcerated, the BOP's response rings hollow.

This Court has authority to order his immediate release into home confinement under the compassionate release statute in 18 U.S.C. § 3582(c)(1)(A)(i) as modified by the First Step Act. This statute, first enacted as part of the Crime Control Act of 1984, granted the district court authority to reduce a defendant's term of imprisonment where there were "extraordinary and

[6] Available at https://www.washingtonpost.com/world/2020/03/26/coronavirus-latest-news/ (last visited Mar. 26, 2020).

compelling reasons" warranting such reduction. However, as originally enacted, the statute only gave the court authority grant compassionate release upon a motion by the Director of the BOP. *See* 18 U.S.C. § 3582(c)(1)(A)(i) (1984).

In 2018, however, Congress enacted the First Step Act, which amended § 3582(c)(1)(A)(i), and gave the Court greater authority. Now, a defendant may file a motion with the court seeking reduction of his sentence for extraordinary and compelling reasons if: 1) the defendant has fully exhausted his administrative remedies; or 2) there has been a lapse of 30 days from the warden's receipt of the defendant's request, whichever is earlier.

Although Mr. Powell has not pursued the traditional path of exhausting administrative remedies, the Court should find them satisfied through the BOP's rejection of the Court's recommendation to have him placed in home confinement because of his health and COVID-19.

Alternatively, if the Court does not find them satisfied, it should waive the exhaustion requirement during this time of emergency. The reality is that any appeal to BOP for administrative assistance in this matter will be futile given its recent decision *not* to follow this Court's recommendation to place him in home confinement. Seeking BOP assistance would also be dangerously time consuming. There is no valid reason to wait 30 days for the formal denial. Waiting for 30 or even 10 days might prove to be too long. Nothing is going to change between now and then other than that Mr. Powell will be in greater danger each day as he sits in the communal barracks, uses the communal bathroom, and eats his meals in the communal cafeteria. *See cf.* Sophie Kaplan, *Union votes 'no confidence' in D.C. Jail leaders for handling of COVID-19*, The Washington Times (Mar. 20, 2020) (noting that the "union representing corrections officers at the D.C. Jail unanimously voted 'no confidence' in the jail's leadership for

'guaranteeing and accelerating the rampant spread of COVID-19' after 50 inmates came in contact with a positive case of the coronavirus").[7]

Courts can dispense with the administrative exhaustion requirement where, as here, there are "exceptional circumstances of peculiar urgency . . . ." *Hendricks v. Zenon*, 993 F.2d 664, 672 (9th Cir. 1993) (*quoting Granberry v. Greer*, 481 U.S. 129, 134 (1987).[8] Indeed, in the compassionate release context, courts have recognized that the exhaustion of administrative remedies can be waived when seeking relief will be futile. *See, e.g.*, *Thody v. Swain*, No. 19-cv-09641, 2019 WL 7842560, *2 (C.D. Cal Nov. 26, 2019) ("A district court may, in its discretion, excuse the failure to exhaust if exhaustion would be futile," but finding the petitioners "conclusory allegations" to be insufficient to establish futility); *Merth v. Puentes*, No.1:19-cv-00251, 2019 WL 3003684, *3 (C.D. Cal July 10, 2019) ("As Respondent did 'not have the authority to grant any provision of the First Step Act without guidance from the Bureau of

[7] Available at https://www.washingtontimes.com/news/2020/mar/20/union-votes-no-confidence-dc-jail-leaders-handling/.

[8] *See also* 28 U.S.C. § 2254(b) (authorizing application for writ of habeas corpus in the absence of exhaustion of State remedies where "circumstances exist that render such process ineffective to protect the rights of the applicant."); *Garza v. Davis*, 596 F.3d 1198, 1203-04 (10th Cir. 2010) (recognizing a futility exception to the exhaustion requirement in 28 U.S.C § 2241 where the defendant sought his placement in a lower-security facility such as a community corrections center or a halfway house); *Woodall v. BOP*, 432 F.3d 235, 239 n.2 (3d Cir. 2005) ("[E]xhaustion would be futile, given that *Woodall* is not challenging the application of the BOP regulations, but their validity."); *Elwood v. Jeter*, 386 F.3d 842, 844 n.1 (8th Cir. 2004) (same); *Boucher v. Lamanna*, 90 F. Supp. 2d 883, 887 (N.D. Ohio 2000) (concluding that exhaustion of administrative remedies would be futile where the BOP's policy on categorizing the prisoner's offense as a violent crime was mandatory, the issue was a legal one that the BOP had consistently defended, and the potential for immediate release counseled timely consideration of the petitioner's case); *Fletcher v. Menard Correctional Center*, 623 F.3d 1171, 1174 (7th Cir. 2010) ("If it takes two weeks to exhaust a complaint that the complainant is in danger of being killed tomorrow, there is no 'possibility of some relief' and so nothing for the prisoner to exhaust.").

Prisons' . . . pursuing administrative remedies would have been futile. Accordingly, exhaustion can be waived.").

There is no longer time to have theoretical discussions about when COVID-19 will come to the D.C. Jail. It has already arrived. Now, each day in custody brings greater and greater risks to Mr. Powell. He has no way to practice "social distancing" or other protectives measures that are mandated by health officials throughout the nation and which promise some hope of surviving the consequences of infection. When more inmates get sick, there will be fewer infirmary beds and greater risk of contracting the virus. When the medical staff becomes ill, there will be fewer people to provide care. And when the correctional staff gets sick, there will be fewer officers available to bring sick people to the infirmary, hospital, or even just keep an eye on who is showing signs of illness. The combination of lack of adequate sanitation, close quarters, and limited medical capacity create the perfect storm. This storm is especially dangerous for people like Mr. Powell who, because of his age and preexisting respiratory problems, is particularly susceptible to contracting a life threatening illness and being unable to survive it.

Mr. Powell respectfully requests that this Court order his immediate compassionate release and impose the following supervised release conditions: 1) that Mr. Powell abide by the standard supervised release conditions; 2) that within 72 hours of release, Mr. Powell contact the U.S. Probation Office by phone for specific reporting instructions; 3) that Mr. Powell reside at his mother's residence, Sandra Powell, in Washington, DC, and be confined to the home—except when attending medical appointments or other activities approved by the U.S. Probation Office—until June 16, 2020.

A proposed order to this effect is attached.

Respectfully submitted,

A.J. KRAMER
Federal Public Defender

_____/s/_____
BENJAMIN FLICK
Research & Writing Attorney
Federal Public Defender's Office
625 Indiana Ave NW, Suite 550
Washington, D.C. 20004
(202) 208-7500

CERTIFICATE OF SERVICE

I certify that on March 27, 2020, a copy of Defendant's Emergency Motion for Compassionate Release was served via electronic mail upon:

Dineen A. Baker
U.S. Attorney's Office for the District of Columbia
555 Fourth Street, NW
Washington, D.C. 20530
(202) 252-6954
Dineen.baker@usdoj.gov

_____/s/_____
BENJAMIN FLICK
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

United States of America, **v.** **Samuel H. Powell,** **Defendant.**	**Case No. 1:94-cr-00316 (ESH)**

ORDER

The Court grants Defendant's Unopposed Motion for Compassionate Release. Accordingly, it is hereby

ORDERED that the Defendant's previously imposed sentence of imprisonment of 262 months is reduced to time-served. It is further

ORDERED that the Defendant be immediately released from custody on his sentence in this case. It is further

ORDERED that the Defendant abide by the standard supervised release conditions. It is further

ORDERED that the Defendant abide by the additional supervised release conditions:

1) Within 72 hours of release, the Defendant shall contact the U.S. Probation Office at 202-565-1300 for specific reporting instructions.

2) The Defendant shall reside at his mother's residence, Sandra Powell, in Washington, DC, and be confined to the home—except when attending medical appointments or other activities approved by the U.S. Probation Office—until June 16, 2020.

SO ORDERED.

DATE: , 2020

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THE HONORABLE ELLEN S. HUVELLE
UNITED STATES DISTRICT JUDGE

Exhibit A

DECLARATION OF DR. MARC STERN, MD MPH IN SUPPORT OF DEFENDANT'S EMERGENCY MOTION

On this 20th day of March, 2020, I hereby declare:

1. My name is Marc Stern. I am a board certified internist specializing in correctional health care. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections. In terms of educational background, I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University in 1992. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

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

3. Through 2013, I taught the National Commission on Correctional Health Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course.

4. In the past four years alone, I have been qualified as an expert in several

jurisdictions on correctional health care systems and conditions of confinement. My full *curriculum vitae* is attached hereto as Exhibit A.

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

6. Due to the recent COVID-19 pandemic affecting the nation and world, I have familiarized myself with the virus from a clinical perspective, including its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through correctional facilities.

7. In the context of a pandemic like the one we currently face, public health and public safety interests are closely intertwined. When and if correctional staffing challenges arise due to the need for staff to quarantine, seek treatment, or care for dependents, managing internal safety in carceral settings becomes even more challenging. Understaffing in the correctional setting is dangerous for staff as well as incarcerated people, and the stress and fear of the current crisis only serve to increase those risks.

8. I have become aware of the D.C. DOC Labor Committee of the Fraternal Order of Police (the correctional officers' union) calling for the resignation of senior jail leadership in light of the D.C. DOC's alleged failure to provide proper protective equipment and guidance from medical professionals trained in COVID-19 response within the jail setting.[1] If accurate, such conditions heighten the urgency of addressing these problems.

[1] https://m.washingtontimes.com/news/2020/mar/20/union-votes-no-confidence-dc-jail-leaders-handling/

9. For these reasons, thoughtful downsizing of the incarcerated population should be implemented in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts.

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

11. Downsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to "flatten the curve" overall—both within the jail setting and without. Early reporting on the impacts of COVID-19, based in part on preliminary data emerging from China, seemed to indicate that the virus' impact would remain relatively mild for younger people. Recent data released by the CDC suggests that this initial narrative is incorrect, and that adults aged 20-44 also face a risk of experiencing severe health outcomes as a result of contracting the disease. The CDC released data based on the reported cases in the United States between February 12 and March 16, 2020. This data showed the thirty-eight percent (38%) of the

hospitalizations from coronavirus occurred in patients under 55 years old.[2] French health officials have released statements saying that half of intensive care admission in that country involve individuals under 65. In the Netherlands, half of intensive care admissions were for people under the age of 50.[3]

12. While the highest risk of death remains among the elderly, it is becoming clear that younger individuals are not protected from severe complications requiring hospitalization and placement in intensive care, using valuable community resources that are expected to become more scarce.

a. At the same time criminal justice authorities work to downsize jail populations, it is critical that the D.C. Department of Corrections, the D.C. Department of Behavioral Health, and any other public agency responsible for maintaining congregate living conditions of detained individuals in the D.C. system immediately undertake the following prevention and planning measures:

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

c. **Immediate Screening**. Correctional authorities must be required to screen each employee or other person entering the facility *every day* to according to current CDC or local health department guidelines A record should be made of each screening.

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[2] Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020, *available at* https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w

[3] https://www.washingtonpost.com/health/2020/03/19/younger-adults-are-large-percentage-coronavirus-hospitalizations-united-states-according-new-cdc-data/

d. **Quarantine.** The jail must establish non-punitive quarantine for all individuals believed to have been exposed to COVID-19, but are not yet symptomatic, and non-punitive isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely infected with COVID-19 must utilize protective equipment as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the incarcerated population. Individuals requiring continued quarantine, isolation, or health care after release from incarceration should be transferred from the institution to the appropriate outside venue.

e. **Institutional Hygiene.** The jail must be required to provide adequate sanitation of high use/high touch areas and cells in accordance with CDC or local health authority guidelines.

    i. This includes a prompt way to dispose of tissues used by incarcerated individuals as well as staff.

f. **Personal Hygiene.** The jail must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis, **free of charge** and ensure replacement products are available as needed. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol when they are in locations or activities where hand washing is not available.

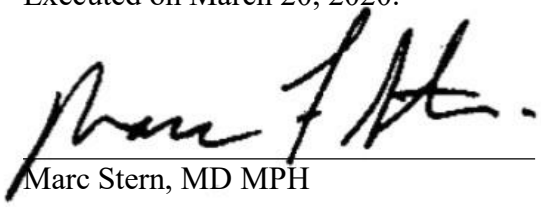
    i. Inmates should be permitted access to cleaning supplies so they may clean their individual cells. This will both keep cells cleaner, and also stem panic

amongst the incarcerated population.

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

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

Executed on March 20, 2020.



Marc Stern, MD MPH

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

March, 2020

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

2007 – present	Affiliate Assistant Professor, Department of Health Services, School of Public Health, University of Washington
1999 – present	Clinical Professor, Fellowship in Applied Public Health (previously Volunteer Faculty, Preventive Medicine Residency), University at Albany School of Public Health
1996 – 2002	Volunteer Faculty, Office of the Dean of Students, University at Albany
1992 – 2002	Associate Clinical/Associate/Assistant Professor of Medicine, Albany Medical College

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

OTHER PROFESSIONAL ACTIVITIES

2016 – present	Chair, Education Committee, Academic Consortium on Criminal Justice Health
2016 – present	Washington State Institutional Review Board ("Prisoner Advocate" member)
2016 – 2017	Mortality Reduction Workgroup, American Jail Association
2013 – present	Conference Planning Committee – Medical/Mental Health Track, American Jail Association
2013 – 2016	"Health in Prisons" course, Bloomberg School of Public Health, Johns Hopkins University/International Committee of the Red Cross
2013 – present	Institutional Review Board, University of Washington ("Prisoner Advocate" member),
2011 – 2012	Education Committee, National Commission on Correctional Health Care
2007 – present	National Advisory Committee, COCHS (Community–Oriented Correctional Health Services)
2004 – 2006	Fellow's Advisory Committee, University of Washington Robert Wood Johnson Clinical Scholar Program
2004	External Expert Panel to the Surgeon General on the "Call to Action on Correctional Health Care"
2003 – present	Faculty Instructor, Critical Appraisal of the Literature Course, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington
2001 – present	Chair/Co-Chair, Education Committee, American College of Correctional Physicians
1999 – present	Critical Appraisal of the Literature Course, Preventive Medicine Residency Program, New York State Department of Health/University at Albany School of Public Health
1999	Co–Chairperson, Education Subcommittee, Workshop Submission Review Committee, Annual Meeting, Society of General Internal Medicine
1997 – 1998	Northeast US Representative, National Association of VA Ambulatory Managers
1996 – 2002	Faculty Mentor, Journal Club, Internal Medicine Residency Program, Albany Medical College
1996 – 2002	Faculty Advisor and Medical Control, 5 Quad Volunteer Ambulance Service, University at Albany
1995 – 1998	Preceptor, MBA Internship, Union College
1995	Quality Assurance/Patient Satisfaction Subcommittee, VA National Curriculum Development Committee for Implementation of Primary Care Practices, Veterans Administration
1994 – 1998	Residency Advisory Committee, Preventive Medicine Residency, New York State Department of Health/School of Public Health, University at Albany
1993	Chairperson, Dean's Task Force on Primary Care, Albany Medical College
1993	Task Group to develop curriculum for Comprehensive Care Case Study Course for Years 1 through 4, Albany Medical College
1988 – 1989	Teaching Effectiveness Program for New Housestaff, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1990	Human Studies Review Committee, School of Allied Health Professions, University of Buffalo
1987 – 1989	Chairman, Subcommittee on Hospital Management Issues and Member, Subcommittee on Teaching of Ad Hoc Committee to Plan Incoming Residents Training Week, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1988	Dean's Ad Hoc Committee to Reorganize "Introduction to Clinical Medicine" Course
1987	Preceptor, Nurse Practitioner Training Program, School of Nursing, University of Buffalo
1986 – 1988	Course Coordinator, Simulation Models Section of Physical Diagnosis Course, University of Buffalo
1986 – 1988	Chairman, Service Chiefs' Continuity of Care Task Force, Veterans Administration Medical Center, Buffalo, New York
1979 – 1980	Laboratory Teaching Assistant in Gross Anatomy, Université Libre de Bruxelles, Brussels, Belgium
1973 – 1975	Instructor and Instructor Trainer of First Aid, American National Red Cross

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

REVIEWER/EDITOR

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

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

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

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS/ABSTRACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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EXPERT TESTIMONY

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

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

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

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

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

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

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

Exhibit B

March 19, 2020

RE: COVID-19 Risks for Detained Populations in Maryland from a group of concerned scientists, physicians, and public health experts

To the Honorable Judges of the Maryland District and Circuit Courts, state and local corrections departments:

We write as a group of concerned physicians and public health experts strongly urging the Maryland court system to address the ongoing global health pandemic by swiftly implementing the following recommendations:

1) **Immediately implement community-based alternatives to detention to alleviate potential exposure to COVID-19 in jails and prisons; and**

2) **Incarcerate as few people as possible in order to mitigate the harm from a COVID-19 outbreak. Detained populations are at high risk to contract a virus like COVID-19 which spreads through respiratory droplets.**

I. Coronavirus Pandemic

In light of the rapid global outbreak of the novel coronavirus disease 2019 (COVID-19), we want to bring attention to the serious harms facing individuals in detention facilities in Maryland. The United States Department of Health and Human Services Secretary Alex Azar declared a public health emergency on January 31, 2020, and Governor Larry Hogan declared a public health emergency in Maryland on March 5, 2020. The state of Maryland has since closed all schools, restaurants and other places of public gathering. The courts have halted regular judicial activity with the exception of emergency matters.

As of March 18, 2020, there have been over 210,000 confirmed cases worldwide with over 8,900 deaths. The US has over 7,500 confirmed cases with 117 deaths. Maryland has 85 confirmed cases and one death. **Public health experts expect the number of confirmed cases to rise exponentially and warn that the situation in the U.S. will get worse before improving.**

II. Public Health Conditions in Detention Facilities Already Poor

Detention facilities are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. For these reasons, transmission of infectious diseases in jails and prisons is incredibly common, especially those transmitted by respiratory droplets. It is estimated that up to a quarter of the US prison population has been infected with tuberculosis[1], with a rate of active TB infection that is 6-10 times higher than the general population.[2] **Flu outbreaks are regular occurrences in jails and prisons across the United States.[3],[4] With a mortality rate 10 times greater than the seasonal flu and a higher R0 (the average number of individuals who can contract the disease from a single infected person)[5] than Ebola, an outbreak of COVID-19 in detention facilities would be devastating.**

III. Risks of a COVID-19 Outbreak in Detention

Emerging evidence about COVID-19 indicates that spread is mostly via respiratory droplets among close contacts[6] and through contact with contaminated surfaces or objects. Reports that the virus may be viable for hours in the air and on surfaces are particularly concerning.[7] Though people are most contagious when they are symptomatic, transmission has been documented in the absence of symptoms. We have reached the point where community spread is occurring in the U.S. The number of cases is growing exponentially, and health systems are already being strained.

Social distancing measures recommended by the Centers for Disease Control (CDC)[8] are nearly impossible in detention facilities and testing remains largely unavailable. In facilities that are already at maximum capacity large-scale quarantines may not be feasible. Isolation may be misused and place individuals at higher risk of neglect and death. COVID-19 threatens the well-being of detained

individuals, as well as the corrections staff who shuttle between the community and detention facilities.

Given these facts, it is only a matter of time before we become aware of COVID-19 cases in a detention setting in which inmates live in close quarters, with subpar infection control measures in place, and whose population represents some of the most vulnerable**. In this setting, we can expect spread of COVID-19 in a manner similar to that at the Life Care Center of Kirkland, Washington, at which over 50% of residents have tested positive for the virus and over 20% have died in the past month.** Such an outbreak would further strain the community's health care system.

In about 16% of cases of COVID-19, illness is severe including pneumonia with respiratory failure, septic shock, multi-organ failure, and even death. Some people are at higher risk of getting severely sick from this illness. This includes people who have serious chronic medical conditions like asthma, lung disease, diabetes, and those who are immunocompromised. There are currently no antiviral drugs licensed by the U.S. Food and Drug Administration (FDA) to treat COVID-19, or post-exposure prophylaxis to prevent infection once exposed.

IV. Maryland Jails are No Exception

Like many states, Maryland has moved into the community transmission phase of this pandemic, and has seen a spike in cases in just over a few days. As courts continue to hear bond hearings and other emergency matters, it is critical that the population of detained people be reduced as much as possible and that extra steps are taken to protect those who are or will remain incarcerated.

Public defenders report that in one jurisdiction, people are brought to bond review hearings in shackles, chained together in close proximity. In other jurisdictions, detained people are crammed into small spaces as they await their bond hearings. Jails and courts should immediately put an end to these practices. Public defenders have also reported that judges are detaining some people on cash bonds that they cannot afford even in cases where there is no public safety threat. Where there is no public safety threat, courts must prioritize public health, and release low-income people

without financial conditions. In addition, in some facilities across the state, detained people must pay a fee to make medical calls—this, in addition to limiting access to soap and hand sanitizer, are practices that jeopardize the individual and collective health of those in jail, including staff. While we are encouraged to hear that some jails are working with the prosecutor and public defender offices to identify vulnerable populations, including the elderly and those with pre-existing conditions, we urge all jurisdictions to take these steps and act swiftly.

This public health crisis requires each and every one of us to re-evaluate how we conduct our lives and care for one and other. Institutions responsible for the care and custody of incarcerated individuals must take unique steps to "flatten the curve" and slow the spread of this virus. We strongly recommend that the courts implement community-based alternatives to detention to alleviate potential exposure in jails. Incarcerating as few people as possible will help mitigate the harm from a COVID-19 outbreak.

Sincerely,

Maryland State Medical Society

Richard Bruno, MD, MPH
Board Certified, Family Medicine
Board Certified, Preventive Medicine
Chair, Public Health Committee, MedChi (Maryland State Medical Society)

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Professor of Medicine, Division of Infectious Diseases,
Johns Hopkins School of Medicine
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[5] The R0 is the reproduction number, defined as the expected number of cases directly generated by one case in a population where all individuals are susceptible to infection.
[6] Close contact is defined as—
a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)
[7] https://www.medrxiv.org/content/10.1101/2020.03.09.20033217v1.full.pdf
[8] https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html

Exhibit C

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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Exhibit D

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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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.

Exhibit E

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.

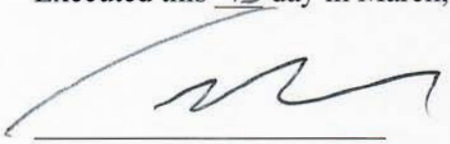
13. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers, particularly 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

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CRIMINAL DIVISION

INFORMATION

DCTN: U20004341
Lockup No: 62
Case No:
Citation Date:

The United States Attorney for the District of Columbia informs the Court that within the District of Columbia:

Defendant's Name:	Samuel H Powell			357275	20022873	01/18/1965
	(First)	(MI)	(Last)	(PDID)	(CCNO)	(DOB)
Also Known As:	Samuel Harry Powell					
	(First)	(Middle)	(Last)			
Address:	2100 MARTIN LUTHER KING JR AVENUE SE, WASHINGTON DC					

1 On or about February 6, 2020, within the District of Columbia, Samuel H Powell unlawfully assaulted and threatened Darryn Thomas in a menacing manner. **(Assault, in violation of 22 D.C. Code, Section 404 (2001 ed.))**

Co-Defendants:

Rule 105: ☐ **Judge:** _____

United States Attorney for the District of Columbia

By: Assistant United States Attorney	**Date: February 7, 2020**
By Officer:	**Badge No.:**
	PSA: 702 **Domestic** ☐

SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
CRIMINAL DIVISION
UNITED STATES
VS
POWELL JR, SAMUEL HARRY

CCN #: **20022873**

Arrest Number: **072003950**

The event occurred on **02/06/2020** at approximately **23:34** at **2850 LANGSTON PLACE SE, WASHINGTON, DC 20020**

BWC Activated.

The offense occurred in PSA 702 on 02/06/2020 at approximately 2330 hours at 2850 Langston PL SE Washington D.C. 20020 which is a Half Way House. Officer Fields #5577, Officer Schwarzer #5610 where working the evening/ midnight tour of duty in full uniform operating scout car 7062 utilizing call sign 7023E.

Officer Fields and Officer Schwarzer were dispatched to the listed location in reference to an assault that occurred. Upon arrival officers came in contact with the building supervisor and V-1 who was attempting to seek medical attention in relation to the incident that occurred. W-1 informed the listed officers that another individual who was later identified as D-1 (Powell, Samuel,Jr, DOB 01/18/1965, B/M), was upstairs in one of the units and that he also needed medical attention. Officer Fields called for additional units when discovering there was another person who needed medical attention, that's when Officer Adams #5571, Officer Bennett #5709, Officer Saint Pierre #5501, and Officer Mays #5639 arrived on the scene. While waiting for DCFEMS to arrive V-1 was laying on the floor in front of the front entrance when D-1 charged downstairs and kicked V-1 in the face with his right foot in front of Officer Schwarzer and the other officers listed arriving on scene. The listed officers were able to detain both D-1 and V-1 who attempted to charge up the stairs and attack D-1.

W-2 stated that while both V-1 and D-1 where in the office he overheard D-1 state that he would kill V-1 and proceeded to follow V-1 in to unit 103 where the incident occurred. D-1 states that the fight started over V-1 continuously harassing and making derogatory comments towards D-1's friend who happens to be transgender and housed in the same location. D-1 states that during dinner he went up to V-1 in an attempt to ask him to leave his friend alone. D-1 states that once they got around the other unit mates V-1 began to get loud, he says that he told V-1 that they could fight in the morning near the bus stop so that it wouldn't bring attention to them. He states that's when V-1 attacked him and that he had to protect himself. D-1 also admitted to the listed officers that he came down and kicked V-1 while he was waiting for medical attention out of anger and frustration.

Based on D-1's statement of what took place, probable cause exists to believe that D-1 committed the offense of Simple Assault. D-1 was placed under arrest for Simple assault, and transported to the 7th District station for processing

The event and acts described above occurred primarily in the District of Columbia and were committed as described by defendant(s) listed in the case caption.

Subscribed and sworn before me this **02/07/2020**

FIELDS, KALYNN / 11465 (02/07/2020) E-SIGNATURE		**BADER, ELLEN / 4524 (02/07/2020) E-SIGNATURE**
Police Officer / CAD#	Unit	Witness / Deputy Clerk
FIELDS, KALYNN / 11465		**BADER, ELLEN / 4524**
Printed Name of Member / CAD#		Printed Name of Witness / Deputy Clerk

The foregoing statement was made under penalty of criminal prosecution and punishment for false statements pursuant to D.C. Code 22-2405

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CRIMINAL DIVISION

PRETRIAL RELEASE CONDITIONS AND ORDER

UNITED STATES OF AMERICA/DISTRICT OF COLUMBIA V. DEFENDANT Samuel Powell	CALENDAR No. _____ PDID No. 357-275 ADDRESS:	LOCKUP No.: 62 CASE No.: 20-CMD-1702 PHONE No.: _____ EMAIL: _____

You are being released on your promise to appear. You must follow all of the conditions of release listed below. These conditions are in effect until the case ends or the conditions are changed by a Judge. You must not commit any criminal offenses while this case is pending. Failure to comply with this order may result in your arrest and additional charges including, but not limited to, Contempt of Court.

✓ Report immediately to Pretrial Services Agency (PSA), Room C-301, to review the conditions of release. Failure to report is a violation of your conditions of release.

SUBSTANCE USE TESTING
- ☐ Report to PSA, Room C-220 for Weekly Testing
- ☐ Evaluation, if positive, weekly testing
- ☐ Diversion Consideration
- ☐ Include Alcohol
- ☐ Full screen

FUGITIVE:
REPORT TO DEMANDING JURISDICTION TO RESOLVE OUTSTANDING WARRANT.
STATE: _____
COUNTY: _____

STAY AWAY/NO CONTACT ORDER:
- ✓ SEE ADDENDUM

FIREARMS:
- ☐ WARNING GIVEN
- ☐ DO NOT POSSESS FIREARMS

REPORTING REQUIREMENTS: *PRETRIAL SERVICES AGENCY*
- ☐ ____ TIMES
- ☐ WEEKLY
- ☐ MONTHLY
- ☐ IN PERSON
- ☐ BY PHONE
- ☐ AS DIRECTED BY PSA

REPORTING REQUIREMENTS: *PROBATION/PAROLE/SUPERVISED RELEASE*
- ☐ IN PERSON
- ☐ BY PHONE
- ☐ BY DATE: ___/___/__

REPORT TO PRETRIAL SERVICES OFFICER;
- ☐ Within 24 HRS
- ☐ Within 48 HRS
- ☐ BY: ___/___/__

PSA MENTAL HEALTH:
- ☐ ASSESSMENT/PLACEMENT
- ☐ MAINTAIN SERVICES
- ☐ SSU PLACEMENT
- ☐ AS DIRECTED BY PSA

SUBSTANCE USE ASSESSMENT/PLACEMENT:
- ☐ ALCOHOL
- ☐ SUBSTANCE USE

URGENT CARE CLINIC:
ROOM 1230 *FOR ASSESSMENT AND PLACEMENT:*
- ☐ ALCOHOL/SUBSTANCE USE DISORDER
- ☐ MENTAL HEALTH

ADDRESS VERIFICATION:
VERIFY YOUR ADDRESS
- ✓ IMMEDIATELY
- ☐ NEXT BUSINESS DAY

LIVE AT:
_____
_____

CURFEW:
- ☐ FROM: ___pm to _____ am
- ☐ DAILY
- ☐ OTHER:_____

ELECTRONIC MONITORING:
- ☐ Orientation 633 Indiana Ave.10TH Floor Suite 1020 at ____ on ___/___/__
- ☐ Home Confinement
- ☐ Location Monitoring

- ☐ CONTACT PSA WITHIN 24 HRS IF YOUR CONTACT INFORMATION CHANGES.

DC/TRAFFIC OFFENSES:
- ☐ DO NOT DRIVE WITHOUT A VALID PERMIT
- ☐ DO NOT DRIVE AFTER CONSUMING ALCOHOL OR ANY ILLEGAL OR CONTROLLED SUBSTANCE, OR ANY MEDICATION THAT CAUSES IMPAIRMENT

DIVERSION/COMMUNITY SERVICE:
- ☐ *REPORT TO ROOM 4203 FOR ASSESSMENT AND CONSIDERATION:*
- ☐ IMMEDIATELY
- ☐ ON: ___/___/____

OTHER REQUIREMENTS:
_____
_____

SANCTION-BASED TREATMENT PROGRAM:
- ☐ Orientation 633 Indiana Ave. 10th floor Suite 1080 at on ___/___/____

PENALTIES FOR: VIOLATION OF RELEASE CONDITIONS:
I agree to comply with the conditions of release and I understand the penalties that I may face for violation of any conditions of release. I understand that if I violate any condition of release I may be subject to revocation of release, detention, prosecution for contempt, and, if I am convicted, a fine of up to $1000 or up to six (6) months in jail or both.

PENALTIES FOR: FAILURE TO APPEAR:
I understand that if I Fail to Appear in this case, a warrant may be issued for my arrest. If convicted of Failure to Appear, I understand that I may be subjected to:
- Up to a $12,500 fine and/or one (1) to five (5) years incarceration if today's charge is a felony charge.
- Up to a $1,000 and/or 90 to 180 days incarceration if today's charge is a misdemeanor.

PENALTIES FOR: CONVICTION WHILE ON RELEASE:
I understand that if I am convicted of a felony while on release in this case, I may face up to a $12,500 fine, one(1) to five (5) years in jail or bc [illegible] that if I am convicted of a misdemeanor 90 to 180 day

Case: 2020 CMD 001702
0007083762
Drt: RELCONCRM

NEXT COURT DATE:
2/20/20 at 9:30 A.M. / P.M. COURTROOM 320
NOTICE: If the Superior Court is closed due to an emergency, you must return to Court on the next business day at 9 a.m. (If you have any questions about the date, time or location of the hearing, call PRETRIAL SERVICES Agency at 202-585-7077.

Your Attorney: _____
Phone: _____ Email: _____

THIRD PARTY CUSTODY
The defendant is placed in the custody of _____ Phone: _____
(Print Name of Custodian)
Custodian: I agree to assume custody of the defendant. I agree (a) to supervise the defendant in accordance with the release conditions above, (b) to use every effort to assure the defendant's appearance at all scheduled hearings or trials, and (c) to notify Pretrial Services Agency at (202) 585-7985 immediately if I learn that the defendant has violated any condition of release or if the defendant is no longer in contact with me.

DEFENDANT'S SIGNATURE

WITNESSED BY: [illegible] AGENCY: OCP87

So ORDERED

JUDGE

DATE: 2/7/20

Copies To: DEFENDANT (Green); DEFENSE COUNSEL (Yellow); PSA (Blue) *(REVISED 9/2019)*

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Criminal Division – Misdemeanor Branch

UNITED STATES OF AMERICA	:	
	:	**Criminal No. 2020-CMD-001702**
v.	:	**7D Community Court**
	:	**Status: March 20, 2020**
Samuel H. Powell Jr.	:	

MOTION TO RECONSIDER AND MODIFY CONDITIONS OF RELEASE

Mr. Samuel Powell, through undersigned counsel, respectfully moves this Court pursuant to D.C. Code § 23-1321(c)(4) for reconsideration of the $50.00 cash bond set in this case. In support of this motion, counsel states the following:

1. Mr. Powell is charged with one count of simple assault arising from an incident that occurred at the Hope Village Half Way House, at which Mr. Powell was completing a federal sentence.

2. On February 7, 2020, Mr. Powell was arraigned in front of Judge Heide Herrmann. The Government did not request a hold, and Judge Herrmann released Mr. Powell on his personal recognizance on the condition that Mr. Powell stay away from the complaining witness.

3. Because Mr. Powell was arrested at the Hope Village Halfway House, Mr. Powell was remanded from the halfway house to the D.C. jail to complete his federal sentence. Mr. Powell was later moved to the Correctional Treatment Facility ("CTF"). Mr. Powell is fifty-five years old and suffers from various health problems, including sleep apnea.

4. On February 20, 2020, the parties in this case agreed to a continuance and set a new status hearing for March 20, 2020. On February 20, there was uncertainty about Mr. Powell's release date from the Federal Bureau of Prisons ("BOP") and his federal probation status. To ensure Mr. Powell maintained the possibility of receiving credit in this case for his detainment at the D.C. Jail and CTF, at the request of the defense, Chief Judge Morin imposed a nominal bond of $50.00.

5. Since the February 20, 2020, status hearing and continuance, the BOP has set a new release date and Mr. Powell's probation status has been clarified. Mr. Powell is set to begin federal supervised release upon his release from BOP custody, which is scheduled for June 16, 2020.

6. D.C. Code § 23-1321(b) provides for a presumption of pretrial release on personal recognizance.

7. Further, the Court must impose the least restrictive condition that will assure Mr. Powell's appearance and the safety of any other person and the community. D.C. Code § 23-1321(c)(3) states:

> A judicial officer may not impose a financial condition under paragraph (1)(B)(xii) or (xiii) of this subsection to assure the safety of any other person or the community, but may impose such a financial condition to reasonably assure the defendant's presence at all court proceedings *that does not result in the preventive detention of the person*, except as provided in § 23-1322(b).
>
> D.C. Code § 1321(c)(3) (emphasis added).

8. In the present case, neither the Government nor Judge Herrmann considered Mr. Powell to be a flight risk. Mr. Powell is currently held at CTF while he finishes his federal

sentence. Both the Government and Judge Herrmann found it unnecessary to preventively detain Mr. Powell in this case.

10. Because Mr. Powell was initially released on personal recognizance and because the bond in this case no longer serves its original precautionary purposes, the money bond will only result in his pretrial detention for this case. Such an outcome would not be the least restrictive condition required to reasonably assure Mr. Powell's appearance at his next court date as well as the safety of the community, and it would result in his preventive detention in violation of D.C. Code § 23-1322(b).. Mr. Powell respectfully asks that the Court eliminate the $50.00 bond in this case.

WHEREFORE, for the aforementioned reasons and any others that may appear to the Court, Mr. Powell respectfully requests that this Motion be granted and that this Court eliminate his bond in this case and, in accordance with D.C. Superior Court policy during this pandemic, continue his case through May 1, 2020.

Respectfully submitted,

/s/Matt Barnes
Matt Barnes, Student Attorney
John M. Copacino #289595, Supervising Attorney
Counsel to Samuel H. Powell Jr.
Georgetown Criminal Justice Clinic
111 F Street, N.W.
Washington, D.C. 20001
(724) 944-9767
mrb240@georgetown.edu

12:56 p.m.

Federal Bureau of Prisons will expand use of home confinement amid pandemic, attorney general says

Attorney General William P. Barr announced Thursday that he had directed the federal Bureau of Prisons to increase the use of home confinement in a bid to stem the impact of the novel coronavirus on the system.

So far, according to the Bureau of Prisons, six inmates and four staff members have contracted the virus at facilities across the country. Barr said Thursday that one of them, an inmate with preexisting conditions at the Oakdale facility in Louisiana, was hospitalized in critical condition.

Barr noted that the bureau had taken several steps to try to prevent an outbreak. Those include suspending almost all visits, stopping transfers among facilities, screening new inmates for fever and quarantining new inmates for 14 days.

Barr said Thursday that authorities would try to "expand home confinement as part of trying to control the spread of this infection." The Bureau of Prisons, he said, was assessing its population to identify people who had already served a substantial portion of their sentence, posed no threat and might have preexisting conditions that would make them particularly vulnerable.

Barr said that the bureau houses 10,000 inmates older than 60 and that about 40 percent of them are serving sentences for violent crimes or sex offenses. He said that about one-third of all inmates have preexisting conditions.

"There are particular concerns in this institutional setting," Barr said. "We want to make sure that our institutions don't become petri dishes and it spreads rapidly through a particular institution."

Sign up for our daily Coronavirus Updates newsletter to track the outbreak. All stories linked in the newsletter are free to access.

By **Matt Zapotosky**