
UNITED STATES DISTRICT COURT
DISTRICT OF KANSAS
(Topeka Docket)

UNITED STATES OF AMERICA,

PLAINTIFF,

CASE NO. 19-40068-03-HTL

vs.

MICHAEL CALVERT,

DEFENDANT.

**REPLY TO GOVERNMENT’S RESPONSE TO DEFENDANT’S MOTION FOR
TEMPORARY RELEASE**

Michael Calvert, by and through Thomas H. Johnson of Petefish, Immel, Hird, Johnson, Leibold & Sloan, L.L.P., replies to the government’s response to his motion for temporary release.

Mr. Calvert has moved the court for temporary release pursuant to 18 USC 3142(i) for the compelling reason that he should be temporarily released from custody under conditions of release because of the increased risk to his health caused by the Covid-19 pandemic. Mr. Calvert has sickle cell disease and the risk of infection while incarcerated at CoreCivic under current circumstances puts him

at a higher risk of adverse health due to his underlying condition than a healthy person with no underlying medical pathology. The risk is higher for two reasons. First, as indicated, he has sickle cell disease. The Center for Disease Control and Prevention (“CDC”) has advised that certain medical conditions increase the risk of serious Covid-19 infection for people of any age with the following medical conditions: lung disease, heart disease, diabetes, or immunocompromised (such as cancer, HIV, autoimmune diseases), blood disorders (**including sickle cell disease**), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy. See Declaration of Dr. Jonathan Louis Gates, M.D, attached hereto, as Attachment 1 at 1, ¶ 3.

Second, he is at a higher risk of infection because he is incarcerated in a facility that is not testing inmates for the infection. See Affidavit of Danielle C. Ompad, PhD, regarding SARS-CoV-2 (otherwise known as COVID-19 in correctional settings), attached hereto as Attachment 2, at ¶ 6 & 7 (the risk of transmission in a correctional setting is high.); see also *United States v. Dante Stephens*, 15-cr-95-AJN, Docket Entry 2798 (S.D.N.Y. March 18, 2020 (Opinion and Order)) (“A comprehensive view of the danger the Defendant poses to the community requires considering all factors—including this one (Covid-19)—on a case-by-case basis—(citing e.g., *United States v. Raihan*, No. 20-cr-68 (BMC (JO), Dkt. No. 20 at 10:12-19 (E.D. N. Y. Mar. 12, 2020) (deciding to continue a criminal defendant on pretrial release rather than order him remanded to the Metropolitan Detention Center due, in part, to Magistrate Judge’s recognition of

the fact that “[t]he more people we crowd into that facility, the more we are increasing the risk to the community”). The danger to the community is real but it also extends to the inmates as well, as people, inmates, lawyers, employees and so forth move in and out of the prison facilities on a daily basis. Inmates with underlying medical conditions that expose them to serious adverse health consequences if infected, like Mr. Calvert, are at a higher risk than an otherwise healthy inmate.

It is well-known that conditions of pretrial detention are ideal for the transmission of the disease.¹ Inmates move in and out of jails and prisons including Federal pretrial detention and the BOP from all over the United States and the world. The people who work at the detention facilities have contact with the inmates in the facilities, as well as families, friends and others outside of the detention facility, and come from the facilities without any screening, much less testing. Additionally, incarcerated people tend to have poorer health than the general population due to drug addiction and other chronic conditions, defined as cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and /or cirrhosis of the liver. Twenty one percent of state and federal prisons and 14% of jail inmates have had tuberculosis, hepatitis B or C, or sexually transmitted infections, excluding HIV or AIDS. Attachment 2 at ¶¶ 6 and 7.

¹ Joseph A. Bick, Infection Control in Jails and Prisons, 45 Clinical Infectious Diseases 1047 (Oct. 2007), <https://doi.org/10.1086/521910>

Medical care is limited in and out of the Federal Bureau of Prisons (BOP), including CoreCivic.² See Attachment 2 at ¶ 8. According to health experts, inmates “are at a special risk of infection, given their living situations,” and are less able to keep themselves safe, which makes controlling infections difficult.³

For Mr. Calvert to be granted release, he must provide the court with a compelling reason. 18 U.S.C. 3142(i). Mr. Calvert is not making a motion for temporary release based on the need to prepare his defense, but rather for the compelling reason that the Covid-19 pandemic, his underlying medical condition, and his incarceration put him at a higher risk than a healthy inmate with no underlying medical condition of contracting the infection and suffering negative long-term health consequences.

The government argues that the risk of Covid-19 infection is not a compelling reason to request temporary release. The Bail Reform Act does not define what a compelling reason is. The government cites Black’s Law definition of compelling as “irreparable harm” and/or Webster’s definition as “forceful, demanding attention and convincing” and claims that “[t]he necessity of temporary release is not analyzed in a vacuum” before citing a series of cases dealing with temporary release in order to prepare a defense. Response at 6. None of these cases is on point. As stated above, Mr. Calvert does not argue for

² Laura M. Maruschak et al., U.S. Dep’t Just., Bureau of Just. Stat., Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12 (rev. Oct. 2016).

³ Letter, Achieving a Fair and Effective COVID-19 Response: an Open Letter to Vice-President Mike Pence, and Other Federal, State and Local Leaders from Public Health and Legal Experts in the United States (March 2, 2020), https://law.yale.edu/sites/default/files/area/center/ghjp/documents/final_covid-19_letter_from_public_health_and_legal_experts.pdf.

temporary release in order to prepare a defense. Mr. Calvert contends that his reason for temporary release, namely to preserve his health from serious negative health consequences, is compelling under both definitions provided by the government; it is both forceful and, if not granted, will likely subject him to irreparable harm and even death, if infected. In *United States v. Dante*, supra, the court held that “the unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic has become apparent” and “necessitate[s] a reconsideration of the Defendant’s bail conditions “ under both 18 U.S.C. 3142(f)(2)(B) and 3142(i).

The district court has the authority to decide whether reason is compelling. 18 U.S.C. § 3142(i); see *United States v. Jones*, 979 F.2d 804, 806 (10th Cir. 1992) (deciding whether circumstances are exceptional under § 3145(c)). In deciding the meaning of an “exceptional” circumstance under 18 U.S.C. § 3145(c), the court, in *United States v., Wages*, 271 Fed. Appx. 726, 727 (10th Cir. 2008), used Webster’s Third New Int’l Dictionary (Unabridged) 791 (G. & C Merriam Co. 1976). There is no reason not to use Webster’s definition of compelling, as “forceful and “demanding attention, convincing” here in the determination of Mr. Calvert’s request for temporary release. The Covid-19 pandemic and the health consequences for communities and inmate populations is forceful and demanding of our immediate attention.

In a more analogous case, the government cites *United States v. Scarpa*, 815 F. Supp. 88 (E.D.N.Y. 1993). *Id.* Mr. Scarpa was arrested and charged with

conspiracy to commit murder and for using a firearm in connection with a violent crime. At his detention hearing, the magistrate judge determined that he was a danger to the community based on the charges and the evidence proffered against him. Nevertheless, he was granted Mr. Scarpa pretrial release (not temporary release) to a community hospital because he had HIV and had been shot in the face. *Id.* at 89-90. The court presumed his HIV would inevitable devolve into AIDS and he would die, likely before trial. *Id.* The court also found that detaining Mr. Scarpa in MCC would expose him to “an unacceptably high risk of infection and death on a daily basis.” *Id.* The court found conditions were available that “would reasonably assure the appearance of the defendant and the safety of the community.” *Id.* at 89. In the context of temporary release, Mr. Scarpa’s situation is compelling given his health. He was infected with HIV. Detaining him in MCC would expose him to an unacceptably high risk of infection and death on a daily basis.

Mr. Calvert faces a similar, unacceptably high risk on a daily basis of contracting a Covid-19 infection that would result in adverse health consequences including death because of his underlying sickle cell disease. He requests temporary release, despite the court’s finding at his detention hearing that he should be detained, until the pandemic Covid-19 virus is under control —i.e., a medical determination that his risk of infection at CoreCivic is minimal because CoreCivic has tested inmates and personnel at CoreCivic for the virus and no one has tested positive for the virus. Mr. Calvert’s chances of not being infected

increase if he is temporarily released. This is not speculation. One has to look no farther than the infection rate of the passengers on the quarantined cruise ships and the people confined in Washington nursing home where infection rates were much higher than the infection rates of people not confined on the ships or in the nursing home or like detainees at CoreCivic or other detention centers.⁴ The cruise ships and the nursing home are situations similar to prisons where once the infection is detected it quickly spreads to others in close proximity who are unable to distance themselves. Unlike the Scarpa Court's assumption that death for Mr. Scarpa was inevitable, death for Mr. Calvert is avoidable if he is protected from the infection by temporarily releasing him from confinement.

The government opposes Mr. Calvert's request for temporary release for several reasons argued in its Response. (i) Mr. Calvert has been detained and temporary release is inconsistent with prior rulings of detention; (ii) Mr. Calvert requests temporary release for an indefinite period of time; (iii) there are no confirmed cases of Covid-19 at CoreCivic; and (iv) Mr. Calvert is safer at CoreCivic than if he were temporarily released.

(i) There is nothing in the Bail Reform Act that would prohibit temporary release for a person who has been ordered detained; provided the person seeking temporary release provides a compelling reason for the release. 18 U.S.C. 3142(i). Indeed, the concept of temporary release presumes prior detention under the

⁴ <https://time.com/5781629/japan-cruise-ship-quarantine/>

statute—i.e., the detained defendant has been found to be a flight risk and/or a danger to himself or others.

Mr. Calvert's reason for requesting temporary release is compelling. He suffers from sickle cell disease—an inherited red blood cell disorder in which host cannot produce enough healthy red blood cells to carry oxygen throughout the body. The CDC has indicated that people who have sickle cell disease are at a heightened risk of infection and negative long-lasting health consequences from Covid-19. There is no cure for the sickle cell disease. And no known cure for the Covid-19 virus at this time. One of the consequences of Sickle cell disease is a weakened immune system through a damaged spleen--the organ that filters blood and acts as part of the body's immune system. People who suffer from sickle cell disease are at a greater risk of infection, including life-threatening infections such as pneumonia.⁵ Covid-19 affects a person's lungs and can cause pneumonia.⁶

In Wuhan, China, Covid-19 when first detected and reported to the World Health Organization (WHO) in December of 2019 was diagnosed as pneumonia of unknown causes. The outbreak was declared a Public Health Emergency of international concern on January 30, 2020. A little over a month later, the WHO declared Covid-19 a global pandemic. Every region of the world and most countries have now reported confirmed Covid-19 cases. Confirmed Covid-19

⁵ <https://www.mayoclinic.org/diseases-conditions/sickle-cell-anemia/symptoms-causes/syc-20355876>

⁶ <https://www.theguardian.com/world/2020/mar/20/coronavirus-what-happens-to-peoples-lungs-when-they-get-covid-19>

cases have been reported in all 50 states, including Kansas and Leavenworth County where CoreCivic is located. Predictions are that the virus will infect half of the global population.⁷ Covid-19 is a health emergency of the highest order.

There are no reported cases of Covid-19 at CoreCivic to date. But Chinese officials confirmed that the virus spread rapidly in jails.⁸ Introduction of the virus in jails could be from visitors, jail staff, attorneys, and/or newly incarcerated persons. The person will likely be asymptomatic and the first Covid-19 case will likely not be detected until that person has shown symptoms. This means that the person could be in the jail transmitting the infection from 2 to 14 days without knowing it. The opportunities for transmission are many. There is no ability for inmates to engage in social distancing, or self-isolation. Cell size is small; inmates live in close contact with each other. Attachment 2 at ¶ 9. Mr. Calvert shares a room with 7 other inmates, and there are 60 people in his pod. Meals are served in community, cafeteria style settings. Toilets are shared by multiple inmates, and the cleaning of surfaces is infrequent. Jails and prisons are not prepared for a Covid-19 outbreak.⁹ An outbreak of Covid-19 in prisons could literally end in the death of many inmates, including Mr. Calvert. *Id.*

⁷ <https://www.cnn.com/2020/03/18/coronavirus-will-infect-half-the-global-population-eiu-predicts.html>

⁸ Rhea Mahbubani, Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500 Cases Have Erupted, Prompting Ouster of Several Officials, *Bus. Insider* (Feb 21, 2020), <https://www.businessinsider.com/500-coronavirus-cases-reported-in-jails-in-china-2020-2>.

⁹ <https://www.vox.com/policy-and-politics/2020/3/17/21181515/coronavirus-covid-19-jails-prisons-mass-incarceration>

(ii) The government argues that Mr. Calvert requests temporary release for an indeterminate period of time and the release is not temporary. Mr. Calvert requests temporary release for the time it takes CoreCivic to test the inmate population and its personnel in order to determine whether anyone is infected, and if so, for those people to be removed, in order to reduce the risk of infection in the facility. The period of time he is released is not within his control, but it is not indefinite, unless the government fails to act and take measures to protect the inmate population from the infection. The court could order a more specific period of time, e.g., two months or until the rate of infection has peaked and the number of new cases begins to fall and there are no cases of Covid-19 at CoreCivic.

The government argues that the U.S. Marshal and CoreCivic personnel are managing the Covid-19 risk at the Leavenworth detention center. As proof of that, the court is told to look at the facility's statement on Covid-19 safety. Response at 4, n. 3. The statement indicates that medical staff participate in the inmate intake process to identify those that are deemed at high-risk of being infected, but no guidelines as to how these determinations are made is provided. Mr. Calvert is deemed high risk by CDC, but not steps have been taken with respect to protecting him. CoreCivic's statement instructs employees to wash hands, not cough or sneeze on anyone, and not to touch your face. The government indicates that CoreCivic is working with state and local agencies to administer test. Upon information and belief, the medical staff consists of a nurse, and no Covid-19 tests are being performed on those detained at CoreCivic.

Related to the issue of infected person is the medical ability to deal with the disease. We know that the health infrastructure in many areas of the United States is under pressure from the spread of the virus and there is concern that if the infection curve is not flatten, the health infrastructure will be insufficient to help all those who need attention. There are now many cases in Kansas and Missouri. Johnson County has experienced community spread, meaning that some people who have been infected don't know how, from whom, or what they got the disease—Covid-19 virus can remain infectious for up to 24 hours on cardboard, and the virus that causes Covid-19 can remain for several hours to several days on other surfaces and aerosols.¹⁰

Covid-19 is typically spread person to person between people in close contact with each other through respiratory droplets produced when an infected person coughs or sneeze. People can have the virus and be contagious without showing symptoms.¹¹ Attachment 2 at ¶ 9 b. Until and unless the CoreCivic population is tested, there is no assurance that the population is not already infected. The longer it takes to test inmates, the worse the situation will be. The federal government has been slow in producing tests, and testing is not yet widely available.¹²

¹⁰ <https://www.sciencedaily.com/releases/2020/03/200320192755.htm>

¹¹ <https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html>
<https://www.nature.com/articles/d41586-020-00822-x>

¹² <https://www.theverge.com/2020/3/17/21184015/coronavirus-testing-pcr-diagnostic-point-of-care-cdc-technology>

(iii) The government argues that no cases have been reported at CoreCivic. But this doesn't mean that the infection is not already in the facility or soon to arrive. Mr. Calvert's temporary release is intended to be a preventative measure. Leavenworth County, however, has two reported cases. Inmates come from other parts of the United States where cases have been reported. Guards and other employees of CoreCivic live in Leavenworth County and go in and out of the facility daily. These people have contact with their families, friends and others. Infection at CoreCivic would appear to be unavoidable unless more measures are taken and testing is done and continued to keep infected people out of the facility.¹³

Once testing begins on a larger scale, the numbers of reported cases will grow and likely confirm a problem at CoreCivic.¹⁴ We know that Covid-19 spreads quickly in closed spaces—cruise ships, nursing homes—jails and prisons are such places. Other jails have begun to release inmates, precisely for this health reason.¹⁵ The government's argument that there are no reported cases of Covid-19 at CoreCivic is unavailing as a rationale for denying Mr. Calvert temporary release, as a reported case would mean that the virus is already at the facility and likely would have infected many other inmates, Mr. Calvert among them. The rational for temporary release is to reduce his risk of infection to keep him safe

¹³ <https://www.statnews.com/2020/03/10/simple-math-alarming-answers-covid-19/>

¹⁴ <https://www.cnbc.com/2020/03/19/coronavirus-live-updates.html>

¹⁵ <https://www.bbc.com/news/world-us-canada-51947802> The Shawnee County Jail has recently given many inmates OR bonds to get them out of the jail for health reasons. This was reported to me by a client who recently was given such a bond.

from the likely serious negative health consequences that will result due to his sickle cell disease if infected.

(iv) The government further argues that since there are no reported cases at CoreCivic, it is actually safer for Mr. Calvert to be detained at CoreCivic than on release. This argument has no merit, and the government cites no scientific authority to support the argument. Mr. Calvert is in a much better position to practice social distancing if he has some control over his living environment than if housed in a crowded correctional facility where all inmates are exposed to a higher risk of infection.

Mr. Calvert has been at CCA since the end of August 2019 without incident. His criminal record contains no felony convictions and the only charged felony is this case. He has two convictions of misdemeanor marijuana possession. Here, he is charged with a conspiracy to distribute controlled substances resulting in death. The only evidence of heroin distribution against him appears to be three controlled buys occurring in December 2017 and February 2018, where he is alleged to have sold heroin with a detectable amount of fentanyl to a government CI. There is no evidence that Mr. Calvert was the person who mixed/cut the drugs with substances like fentanyl or evidence that the amount of fentanyl in the heroin he has alleged to have sold was toxic and would have resulted in death. He has not been convicted of a crime of violence; nor has he fled from authorities. Indeed, when he learned that the current case, which was initially charged as a state case in Riley County, Kansas, he turned himself in. Mr. Calvert is a good risk for the

court on temporary release, and the court can fashion conditions of temporary release to assure that returns to custody, including GPS monitoring and/or house arrest.

For the reasons given above, Mr. Calvert respectfully asks the court to approve his request for temporary release.

Respectfully submitted,

/s/ Thomas H. Johnson #13688
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CERTIFICATE OF SERVICE

I hereby certify that on the 20th day of March 2020, I electronically filed the foregoing reply to the government's response to our motion for temporary release from custody with the clerk using the CM/ECF system, which will notify all attorneys of record.

/s/ Thomas H. Johnson

ATTACHMENT 1

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 myocarditis, 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

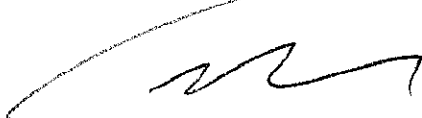
represents the largest known outbreak in the United States, and one the largest known outbreaks in the world as of March 12, 2020.

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.

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

Dr. Jonathan Louis Golob

ATTACHMENT 2

Affidavit of Danielle C. Ompad, PhD regarding SARS-CoV-2 infection (otherwise known as COVID-19) in correctional settings

I, Dr. Danielle C. Ompad, state that the following is a true and accurate statement to the best of my knowledge and belief:

1. I am currently an Associate Professor of Epidemiology at the New York University School of Global Public Health. I have a BS in biology from Bowie State University, and an MHS and PhD in infectious disease epidemiology from the Johns Hopkins School of Public Health.
2. Classically trained as an infectious disease epidemiologist, I am an expert on social determinants of health associated with urban life. My research is focused on the health and wellbeing of people living in urban settings, especially communities that are highly marginalized and vulnerable. Many of these communities have high rates of heroin, crack, and/or cocaine use. My program of research is focused on individual- and structural-level risk and protective factors for the initiation, use, and cessation of specific drugs as well as risk for infectious diseases such as HIV, hepatitis B and C viruses (HBV and HCV), and sexually transmitted infections like herpes and human papillomavirus. Additional and related programs of research include (1) understanding sexual risk and (2) vaccine access among people who use drugs (PWUD) and other vulnerable populations.
3. I have been working with people who use drugs since 1997, many of whom have experience with the criminal justice system. I am providing this affidavit about the risk of SARS-CoV-2 infection, also known as COVID-19 or the novel coronavirus, because correctional settings may be particularly vulnerable to the effects of this pandemic.
4. I am the author of more than 125 peer-reviewed research articles, six book chapters, and two encyclopedia entries.
5. **Overview of the COVID-19 pandemic**
 - a. The first case of COVID-19 was diagnosed in Wuhan, China on 29 December 2019. The virus is transmitted through droplets and contaminated surfaces,¹ and possible airborne transmission.² Both symptomatic and asymptomatic people can transmit COVID-19.³ The average incubation period (i.e., time from infection to symptoms) for COVID-19 has generally been reported to be 5.1 days and 97.5% of those who develop symptoms will do so within 11.5 days.⁴
 - b. Older adults and people with underlying health conditions like cardiovascular diseases, respiratory diseases, diabetes, and liver disease are at increased risk for severe COVID-

¹ Adhikari SP, Meng S, Wu YJ, et al. Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: a scoping review. *Infect Dis Poverty*. 2020;9(1):29. Published 2020 Mar 17. doi:10.1186/s40249-020-00646-x

² van Doremalen N, Bushmaker T, Morris DH, et al. Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1 [published online ahead of print, 2020 Mar 17]. *N Engl J Med*. 2020; 10.1056/NEJMc2004973. doi:10.1056/NEJMc2004973

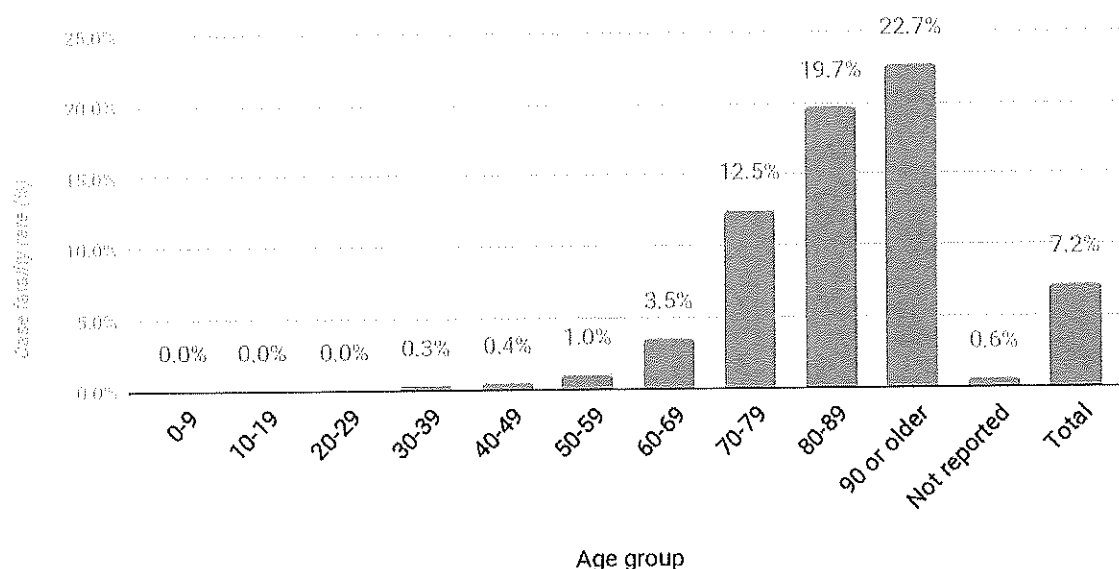
³ Tong ZD, Tang A, Li KF, et al. Potential Presymptomatic Transmission of SARS-CoV-2, Zhejiang Province, China, 2020 [published online ahead of print, 2020 May 17]. *Emerg Infect Dis*. 2020;26(5):10.3201/eid2605.200198. doi:10.3201/eid2605.200198

⁴ Lauer SA, Grantz KH, Bi Q, et al. The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application [published online ahead of print, 2020 Mar 10]. *Ann Intern Med*. 2020;10.7326/M20-0504. doi:10.7326/M20-0504

19 complications and death. Of note, risk for death appears to increase substantially with age although actual age-specific death rates should be considered in the context of a lack of widespread testing in most countries, including the U.S. In most countries testing is being conducted among hospitalized cases and health care workers. South Korea is the exception, where mild and severe cases have been tested with over 300,000 people have been tested.

- c. The case fatality rate (CFR) is the number of deaths divided by the number of people with COVID-19. Note that the denominator (i.e., number of people with COVID-19) is determined by the number of people tested as well as the testing criteria. Therefore, the CFR is likely inflated (i.e., an overestimate). The World Health Organization estimates that the overall case fatality rate is 3.4%.⁵ Table 1 provides case fatality rates from Italy by decade of age. You can see that risk of death starts increasing among people in their sixties and then increases dramatically for each decade of life thereafter.

Figure 1. COVID-19 case fatality rates by age group as of 15 March 2020, Italy



- d. Recent reporting revealed that young people are experiencing severe disease. The New York Times reported that approximately 40% of hospitalized COVID-19 cases were under the age of 60.⁶
- e. Prevention of COVID-19 transmission is highly dependent on physical social distancing (i.e., at least six feet from other people) as well as hand washing and sanitizing with an alcohol-based hand sanitizer. Surfaces should be cleaned and disinfected regularly. Confirmed COVID-19 cases (with or without symptoms) must be quarantined to prevent transmission. People who have been exposed to someone who has (or may have) COVID-19 are asked to self-isolate for at least two weeks. Many US jurisdictions are

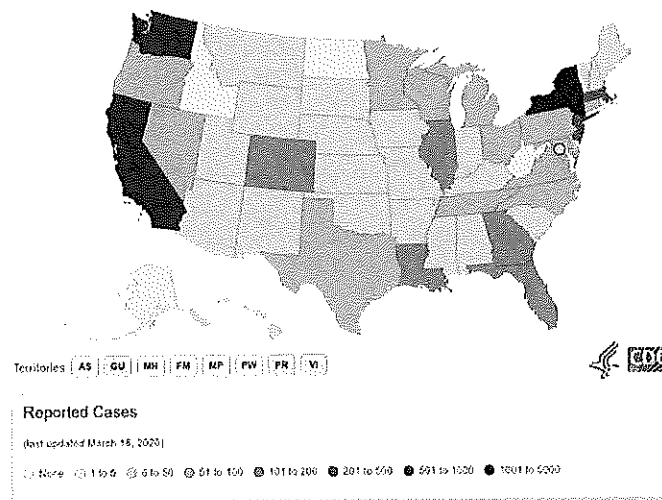
⁵ WHO Director-General's opening remarks at the media briefing on COVID-19 - 3 March 2020 - World Health Organization, March 3, 2020

⁶ Belluck P. Younger Adults Make Up Big Portion of Coronavirus Hospitalizations in U.S. New York Times. 20 March 2020

beginning to ask residents to engage in physical social distancing and self-isolation. Non-essential workers and businesses are being asked to close.

- f. As 20 March 2020, the Johns Hopkins COVID-19 dashboard⁷ reports that there are 259,215 cases worldwide and 11,283 deaths. COVID-19 cases have been detected in all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands (Figure 2). As of 20 March 2020, there are 17,303 reported cases and 215 deaths in the United States.⁸ Testing for COVID-19 infections has not been fully implemented and is mainly targeted to hospitalized people with COVID-19 symptoms (i.e., dry cough, fever, shortness of breath, acute respiratory distress syndrome), those with contact with a suspected or known cases, and health care workers with symptoms, known exposure to a case, or travel history to countries with cases; people with mild symptoms are not generally being tested because of the limited supply of tests. As a result, any case counts are an underestimate of the true number of cases.

Figure 2. Distribution of COVID-19 cases in the United States as of 18 March 2020 (U.S. Centers for Disease Control and Prevention)

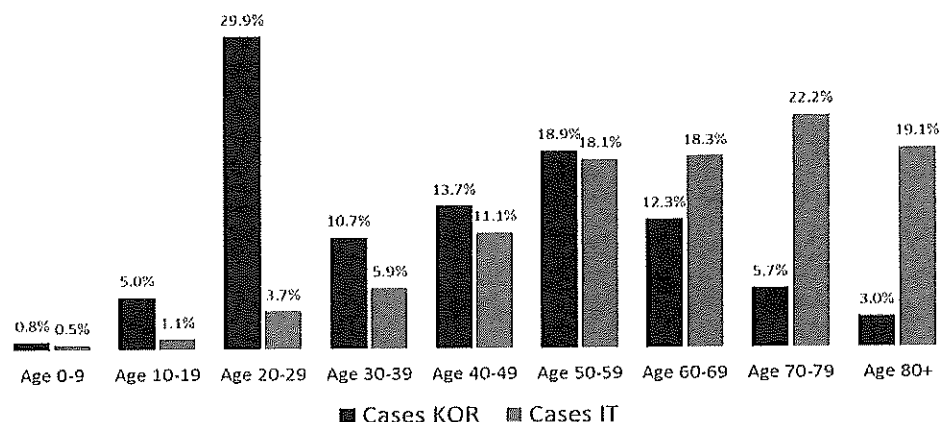


⁷ <https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>

⁸ Reported cases include both confirmed and presumptive positive cases of COVID-19 reported to CDC or tested at CDC since January 21, 2020, with the exception of testing results for persons repatriated to the United States from Wuhan, China and Japan.

- g. Data from South Korea, where testing is conducted for mild and severe cases (more than 300,000 tested so far),⁹ suggest that individuals in their 20s have the highest prevalence of COVID-19 infection (Figure 3).¹⁰

Figure 3. COVID-19 cases (%) in South Korea and Italy by age group



6. Transmission risk in correctional settings

- The risk of transmission of COVID-19 in correctional settings is high. Correctional facilities are often crowded and people who are incarcerated (PWI) are likely unable to maintain the requisite social distance of six feet. This is especially an issue within individual cells, where bunked beds make distancing of six feet impossible. Cafeteria areas and dormitory-type sleep quarters also create challenges to social distancing depending on how these spaces are organized and the number of people in the space at any one time.
- Correctional facilities have significant flows of people from the community into the facility and back out. Correctional staff, visitors, and attorneys come to and from the facility from their home communities. In addition, newly incarcerated individuals, who have been circulating in the community prior to entering the facility, are coming into facilities. As a result, current PWI are likely to be exposed to COVID-19 through their interactions with correctional staff, visitors, attorneys, and newly arrived PWI.
- Generally, there is a shortage of personal protective equipment (PPE) such as N95 masks in the U.S. Local jurisdictions are prioritizing health care facilities for scarce PPE, making access to such protective gear challenging for correctional facility staff.
- Client reports from nine Massachusetts correctional facilities revealed that PWI at two facilities did not have access to soap at all and only three had access to free soap. In four facilities, PWI did not have access to hand sanitizer.
- Thus, the risk for transmission in correctional facilities may be high. This will have implications for the general population from which correctional staff, visitors, and attorneys come and as a result, may place communities in which correctional facilities are located at enhanced risk of COVID-19 transmission as well as challenging the limited health care infrastructure and staff in local hospitals.

⁹ Zastrow M. South Korea is reporting intimate details of COVID-19 cases: has it helped? [news]. Nature 2020.

¹⁰ <https://medium.com/@andreasbackhausab/coronavirus-why-its-so-deadly-in-italy-c4200a15a7bf>

7. Risk for severe disease and death among incarcerated individuals

- a. If COVID-19 enters correctional facilities, the likelihood that there will be severe cases is high. According to the Massachusetts Department of Corrections, 983 PWI (11.2%) were aged 60 and over in 2019 among 8,784 total PWI. As previously mentioned, older adults are at increased risk for severe COVID-19 complications as well as death.
- b. According to data from the 2011-2012 National Inmate Survey,¹¹ there is a substantial burden of disease among correctional populations. Approximately half of state and federal prisoners and jail inmates have ever had a chronic medical condition (defined as cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and/or cirrhosis of the liver). Twenty-one percent of state and federal prisoners and 14% of jail inmates have ever had tuberculosis, hepatitis B or C, or sexually transmitted infections (excluding HIV or AIDS). Table 1 displays lifetime prevalence of specific chronic conditions with implications for COVID-19 severity and death among state and federal prisoners and jail inmates. Note that older prisoners were about three times more likely than younger persons to have had a chronic condition or infectious disease in their lifetime.

Table 1. Lifetime prevalence of specific chronic conditions and infectious diseases with implications for COVID-19 severity and death among state and federal prisoners and jail inmates, 2011-2012 National Inmate Survey

Condition	State and federal prisoners (%)	Jail inmates (%)
Cancer	3.5	3.6
Diabetes	9.0	7.2
Stroke-related problems	1.8	2.3
Heart-related problems	9.8	10.4
Kidney-related problems	6.1	6.7
Asthma	14.9	20.1
Cirrhosis of the liver	1.8	1.7
Tuberculosis	6.0	2.5
Hepatitis B	10.9	1.7
Hepatitis C	2.7	5.6
HIV/AIDS	9.8	1.3

¹¹ Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011-12. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2015 Feb.

- c. Collectively, these data suggest that there is a risk that a significant proportion of PWI will experience severe COVID-19 disease requiring hospitalization and many are at risk of dying from COVID-19.

8. Healthcare response and correctional settings

- a. Healthcare provision in correctional settings is limited and a rapid increase in COVID-19 cases may overwhelm the capacity of a jail or prison's healthcare facilities. Moreover, health care providers in correctional settings may not have the equipment (i.e., ventilators) or specialty skill set to support PWI with severe COVID-19 disease.
- b. There is already growing concern in the medical community that the need for intensive care unit beds and ventilators will outstrip the supply. We saw this in China, where new hospitals were built to treat the surge in patients. We are seeing this now in northern Italy, where unused wards are being retrofitted to serve as ICUs.
- c. Severe COVID-19 cases in correctional facilities may be transferred to local hospitals. An outbreak at a local correctional facility, where there is a high likelihood of rapid transmission to a large number of people, could quickly overwhelm local hospitals.

9. What would an outbreak look like in a correctional facility?

- a. There are no descriptions of a COVID-19 outbreak in a correctional facility to date. However, we can hypothesize what one may look like drawing on published reports of influenza and tuberculosis outbreaks – both respiratory infections – in correctional facilities.^{12,13}
- b. Introduction of the SAR-CoV-2 virus to the correctional facility could be from visitors, correctional staff, attorneys, and/or a newly incarcerated person. The person will likely be asymptomatic. As a result, the first facility-acquired COVID-19 case will not be detected until the that person is shows symptoms. This means that the person could have transmitting the infection from 2 to 14 days without knowing it.
- c. The opportunities for transmission in correctional facilities are myriad and there is limited ability for PWI to engage in social distancing or self-isolation. The minimum cell size in the U.S. is 80 square feet based on American Correctional Association standards.¹⁴ Some cells in Massachusetts are approximately 73 square feet. Beds can be bunked, ensuring that PWI are within six feet of each other in shared cells. Community meals in cafeteria/chow hall type settings as well as group recreation time in gyms and outdoor spaces also make social distancing challenging.
 - i. At the Hampshire House of Corrections and North Central Correctional Institution in Gardner, groups of inmates are still going to "chow" and sitting and eating together with no instructions regarding social distancing.
 - ii. At the Middleton House of Corrections, a whole unit has been quarantined in the gym.
- d. Given the crowded conditions as well as challenges with social distancing and access to PPE for staff, the infections could spread rapidly and by the time the first case is identified many will have already been infected.
- e. After the first symptomatic case is identified, the number of additional cases is likely to occur rapidly over the next days and weeks. The hospitalization rate is unknown at this

¹² Sosa LE, Lobato MN, Condren T, Williams MN, Hadler JL. Outbreak of tuberculosis in a correctional facility: consequences of missed opportunities. *Int J Tuberc Lung Dis*. 2008;12(6):689–691.

¹³ Awofeso N, Fennell M, Waliuzzaman Z, et al. Influenza outbreak in a correctional facility. *Aust N Z J Public Health*. 2001;25(5):443–446.

¹⁴ http://www.aca.org/ACA_Prod_IMIS/docs/Standards%20And%20Accreditation/RH%20-%20Proposed%20Standards%20.%2012.4.2015.pdf

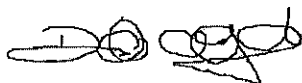
point, but given the high burden of high-risk conditions among PWI, we can anticipate the jail and prison health facilities will face shortages of beds, ventilators, PPE, testing supplies, and masks.

- f. When correctional facility health services are exhausted, or the type of care needed for a patient is beyond the capacity of the facility, PWI COVID-19 cases will need to be transferred to local hospitals.

10. Summary

- a. Incarcerating individuals who cannot make bail as well as current PWI that do not pose a danger to the community may increase the risk of COVID-19 outbreaks in correctional facilities when we consider the following issues:
 - i. COVID-19 transmission is possible even when people are asymptomatic and the average incubation period is five days.
 - ii. According to the Massachusetts Department of Corrections, 19.4% of PWI in 2019 were between the ages of 18 and 29. Some evidence suggests that this age group has the highest prevalence of COVID-19.
 - iii. There is high risk for transmission in correctional facilities.
 - iv. A substantial proportion of PWI aged 60 and older and/or with health conditions with implications for severe COVID-19 disease requiring hospitalization and possibly resulting in death
 - v. The implications of a correctional facility outbreak for local hospitals.
- b. By acting now and releasing a significant number of people who are currently detained you will save lives. You can prevent outbreaks in correctional facilities by reducing the number of people who are coming in from the community and reducing the number of people at risk within the facilities. This action would then protect correctional officers, attorneys, and PWI as well as the families of these groups.
- c. This would result in the courts contributing to "Flatten the Curve" efforts because it will increase the ability of PWI and correctional facility staff to engage in social distancing inside as well as allowing released criminal-justice involved people to engage in social distancing and/or self-isolation (as appropriate) in the community, thereby reducing the likelihood of transmission and disease.

Signed this 20th day of March, 2020,



Danielle C. Ompad, PhD¹⁵
Associate Professor of Epidemiology
New York University School of Global Public Health

¹⁵ This statement reflects my own views. I do not speak for New York University or any department therein.

ATTACHMENT 3

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.
2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.
3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.
4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
5. I am being paid \$1,000 for my time reviewing materials and preparing this report.
6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.
9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.
10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.
11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.
12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

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

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.¹ This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.
14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.
15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.
16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.
18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

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

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

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

III. Profile of COVID-19 as an Infectious Disease⁴

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

² *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012),

<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

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

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

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.⁵ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.⁶ Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.
22. The care of people who are infected with COVID-19 depends on how seriously they are ill.⁷ People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.
24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.⁸ To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

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

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

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

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

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

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

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice: New Jersey, Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.
26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.
27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.
28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.
29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.
30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

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

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.
32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.
33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.
34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.
35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.
37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.
38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.
39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.
40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

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

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

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

March 15, 2020
New Haven, Connecticut



Dr. Jaimie Meyer

EXHIBIT A

CURRICULUM VITAE

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

Education:

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

Career/Academic Appointments:

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

Board Certification:

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

Professional Honors & Recognition:

International/National/Regional

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

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

Yale University

2014	Women's Faculty Forum, Public Voices Thought Leadership Program Fellow
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Grants/Clinical Trials History:**Current Grants**

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

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

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

Jaimie Meyer, MD, MS, FACP

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

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

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

Past Grants

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

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

Total costs for project

period: \$75,000.00
 Project period: 1/31/2014 - 10/31/2015

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

Pending Grants

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

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:**International/National**

- 2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"
- 2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"
- 2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"
- 2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"
- 2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"
- 2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

- 2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"
- 2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"
- 2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"
- 2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"
- 2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:**International/National**

- 2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"
- 2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"
- 2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"
- 2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"
- 2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"
- 2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""
- 2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"
- 2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"
- 2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"
- 2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

- 2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"
- 2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"
- 2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"
- 2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"
- 2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"
- 2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"
- 2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"
- 2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"
- 2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"
- 2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"
- 2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"
- 2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"
- 2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

- 2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"
- 2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"
- 2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"
- 2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"
- 2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"
- 2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"
- 2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"
- 2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

- 2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"
- 2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"
- 2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

- 2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"
- 2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

- 2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers
- 2019 - present Reviewer, Yale DCFAR Pilot Projects
- 2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)
- 2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

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

Journal Service

Editor/Associate Editor

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

Reviewer

- 2019 - present Reviewer, JAIDS
- 2012 - present Reviewer, Addiction Sci and Clin Pract
- 2012 - present Reviewer, Addictive Behav Reports
- 2012 - present Reviewer, AIDS Care
- 2012 - present Reviewer, Social Science and Medicine
- 2012 - present Reviewer, SpringerPlus
- 2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy
- 2012 - present Reviewer, Women's Health Issues
- 2012 - present Reviewer, Yale Journal of Biology and Medicine
- 2012 - present Reviewer, AIMS Public Health
- 2012 - present Reviewer, American Journal on Addictions
- 2012 - present Reviewer, American Journal of Epidemiology
- 2012 - present Reviewer, American Journal of Public Health
- 2012 - present Reviewer, Annals Internal Medicine
- 2012 - present Reviewer, BMC Emergency Medicine
- 2012 - present Reviewer, BMC Infectious Diseases
- 2012 - present Reviewer, BMC Public Health
- 2012 - present Reviewer, BMC Women's Health

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

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

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

American College of Physicians

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

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

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

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

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

Medical School Committees

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

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

Public Service

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

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

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

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

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

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

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

4. Chen NE, **Meyer JP**, Avery AK, Draine J, Flanigan TP, Lincoln T, Spaulding AC, Springer SA, Altice FL. Adherence to HIV treatment and care among previously homeless jail detainees. *AIDS And Behavior* 2013, 17:2654-66.
5. Althoff AL, Zelenev A, **Meyer JP**, Fu J, Brown SE, Vagenas P, Avery AK, Cruzado-Quifones J, Spaulding AC, Altice FL. Correlates of retention in HIV care after release from jail: results from a multi-site study. *AIDS And Behavior* 2013, 17 Suppl 2:S156-70.
6. Williams CT, Kim S, **Meyer J**, Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. *AIDS And Behavior* 2013, 17 Suppl 2:S195-202.
7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. *International Journal Of Prisoner Health* 2013, 9:124-41.
8. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Frequent emergency department use among released prisoners with human immunodeficiency virus: characterization including a novel multimorbidity index. *Academic Emergency Medicine : Official Journal Of The Society For Academic Emergency Medicine* 2013, 20:79-88.
9. **Meyer JP**, Cepeda J, Springer SA, Wu J, Trestman RL, Altice FL. HIV in people reincarcerated in Connecticut prisons and jails: an observational cohort study. *The Lancet. HIV* 2014, 1:e77-e84.
10. **Meyer JP**, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender disparities in HIV treatment outcomes following release from jail: results from a multicenter study. *American Journal Of Public Health* 2014, 104:434-41.
11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. *JAMA Internal Medicine* 2014, 174:721-9.
12. **Meyer JP**, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. *American Journal Of Public Health* 2015, 105:1901-10.
13. Boyd AT, Song DL, **Meyer JP**, Altice FL. Emergency department use among HIV-infected released jail detainees. *Journal Of Urban Health : Bulletin Of The New York Academy Of Medicine* 2015, 92:108-35.
14. Shrestha R, Karki P, Altice FL, Huedo-Medina TB, **Meyer JP**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and anticipation of practicing safer drug- and sex-related behaviors among high-risk drug users on methadone treatment. *Drug And Alcohol Dependence* 2017, 173:107-116.
15. Peasant C, Sullivan TP, Weiss NH, Martinez I, **Meyer JP**. Beyond the syndemic: condom negotiation and use among women experiencing partner violence. *AIDS Care* 2017, 29:516-523.
16. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, **Meyer JP**, El-Bassel N, Mayer KH, Kamarulzaman A, Altice FL. Prevalence of Human Immunodeficiency Virus and Sexually Transmitted Infections Among Cisgender and Transgender Women Sex Workers in Greater Kuala Lumpur, Malaysia: Results From a Respondent-Driven Sampling Study. *Sexually Transmitted Diseases* 2017, 44:663-670.
17. Hoff E, Marcus R, Bojko MJ, Makarenko I, Mazhnaya A, Altice FL, **Meyer JP**. The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. *Journal Of Substance Abuse Treatment* 2017, 83:36-44.

18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. *AIDS Care* 2018, 30:1282-1289.
19. Peasant C, Sullivan TP, Ritchwood TD, Parra GR, Weiss NH, **Meyer JP**, Murphy JG. Words can hurt: The effects of physical and psychological partner violence on condom negotiation and condom use among young women. *Women & Health* 2018, 58:483-497.
20. Loeliger KB, Altice FL, Desai MM, Ciarleglio MM, Gallagher C, **Meyer JP**. Predictors of linkage to HIV care and viral suppression after release from jails and prisons: a retrospective cohort study. *The Lancet. HIV* 2018, 5:e96-e106.
21. Odio CD, Carroll M, Glass S, Bauman A, Taxman FS, **Meyer JP**. Evaluating concurrent validity of criminal justice and clinical assessments among women on probation. *Health & Justice* 2018, 6:7.
22. Loeliger KB, Altice FL, Ciarleglio MM, Rich KM, Chandra DK, Gallagher C, Desai MM, **Meyer JP**. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. *The Lancet. HIV* 2018, 5:e617-e628.
23. Loeliger KB, **Meyer JP**, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. *PLoS Medicine* 2018, 15:e1002667.
24. Azbel L, Wegman MP, Polonsky M, Bachiredy C, **Meyer J**, Shumskaya N, Kurmanalieva A, Dvoryak S, Altice FL. Drug injection within prison in Kyrgyzstan: elevated HIV risk and implications for scaling up opioid agonist treatments. *International Journal Of Prisoner Health* 2018, 14:175-187.
25. Peasant C, Montanaro EA, Kershaw TS, Parra GR, Weiss NH, **Meyer JP**, Murphy JG, Ritchwood TD, Sullivan TP. An event-level examination of successful condom negotiation strategies among young women. *Journal Of Health Psychology* 2019, 24:898-908.
26. Ranjit YS, Azbel L, Krishnan A, Altice FL, **Meyer JP**. Evaluation of HIV risk and outcomes in a nationally representative sample of incarcerated women in Azerbaijan, Kyrgyzstan, and Ukraine. *AIDS Care* 2019, 31:793-797.
27. Rhodes T, Azbel L, Lancaster K, **Meyer J**. The becoming-methadone-body: on the onto-politics of health intervention translations. *Sociology Of Health & Illness* 2019, 41:1618-1636.
28. Olson B, Vincent W, **Meyer JP**, Kershaw T, Sikkema KJ, Heckman TG, Hansen NB. Depressive symptoms, physical symptoms, and health-related quality of life among older adults with HIV. *Quality Of Life Research : An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation* 2019.

Chapters, Books, and Reviews

29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. *Drug And Alcohol Dependence* 2010, 112:178-93.
30. **Meyer JP**, Springer SA, Altice FL. Substance abuse, violence, and HIV in women: a literature review of the syndemic. *Journal Of Women's Health (2002)* 2011, 20:991-1006.
31. **Meyer JP**, Chen NE, Springer SA. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. *AIDS Research And Treatment* 2011, 2011:680617.
32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. *Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America* 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. *Infectious Disease Reports* 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. *Sexually Transmitted Infections* 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. *Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America* 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. *Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award)*. Oxford University Press 2015. ISBN 9780199360574.
37. **Meyer JP**, Moghimi Y, Marcus R, Lim JK, Litwin AH, Altice FL. Evidence-based interventions to enhance assessment, treatment, and adherence in the chronic Hepatitis C care continuum. *The International Journal On Drug Policy* 2015, 26:922-35.
38. Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J**. *Infectious Diseases in Underserved Populations*. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. *Current Diagnosis and Treatment- Infectious Diseases*. McGraw-Hill Medical 2016.
39. **Meyer JP**, Womack JA, Gibson B. Beyond the Pap Smear: Gender-responsive HIV Care for Women. *The Yale Journal Of Biology And Medicine* 2016, 89:193-203.
40. **Meyer JP**, Muthulingam D, El-Bassel N, Altice FL. Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions. *AIDS And Behavior* 2017, 21:3527-3548.
41. Shrestha R, McCoy-Redd B, **Meyer J**. Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. *The Opioid Epidemic and Infectious Diseases*. Elsevier 2019.
42. **Meyer JP**, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. *Drug And Alcohol Dependence* 2019, 197:158-163.

Peer-Reviewed Educational Materials

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

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. *Journal Of General Internal Medicine* 2014, 29:1164.
46. Brinkley-Rubinstein L, Dauria E, Tolou-Shams M, Christopoulos K, Chan PA, Beckwith CG, Parker S, **Meyer J**. The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems. *Current HIV/AIDS Reports* 2018, 15:93-95.
47. **Meyer JP**. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. *Journal Of Women's Health (2002)* 2019, 28:1017-1018.

Case Reports, Technical Notes, Letters

48. **Paul J.** Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
49. How J, Azar MM, **Meyer JP.** Are Nectarines to Blame? A Case Report and Literature Review of Spontaneous Bacterial Peritonitis Due to *Listeria monocytogenes*. Connecticut Medicine 2015, 79:31-6.
50. Vazquez Guillamet LJ, Malinis MF, **Meyer JP.** Emerging role of *Actinomyces meyeri* in brain abscesses: A case report and literature review. IDCases 2017, 10:26-29.
51. Harada K, Heaton H, Chen J, Vazquez M, **Meyer J.** Zoster vaccine-associated primary varicella infection in an immunocompetent host. BMJ Case Reports 2017, 2017.
52. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP.** Answer to December 2017 Photo Quiz. Journal Of Clinical Microbiology 2017, 55:3568.
53. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP.** Photo Quiz: Peripheral Blood Smear in a Ugandan Refugee. Journal Of Clinical Microbiology 2017, 55:3313-3314.

Scholarship In Press

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

ATTACHMENT 4

Declaration of Dr. Marc Stern

I, Marc Stern, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

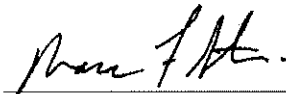
12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the detention center, either among staff or detainees.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

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

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

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

Executed this __15th__ day in March, 2020 in Tumwater, Washington.

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

Dr. Marc Stern

ATTACHMENT 5

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.

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

² See <https://experience.arcgis.com/experience/685d0ace521648f8a5beecce1b9125cd>, accessed March 13, 2020.

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

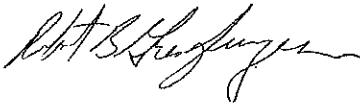
6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.
7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.
8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. At least one nursing home in the Seattle area has had cases of COVID-19 and has been quarantined.
9. The Seattle metropolitan area, hit hard by COVID, is the epicenter of the largest national outbreak at this time. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the immigration detention facility in Tacoma, Washington. Immigration courts and the ICE field office in Seattle have already closed this month due to staff exposure to COVID-19.
10. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.
11. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the “social distancing” needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.
12. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.
13. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks

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

14. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.
15. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from NWDC by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with the Pierce County or Washington State Department of Health.

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

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

A handwritten signature in black ink, appearing to read "Robert B. Greifinger", with a stylized, flowing script.

Robert B. Greifinger, M.D.